

# HEALTH QUESTIONNAIRE

Initial  Re-Eval

Use a No. 2 pencil to mark your answers. When marking in an Other bubble please explain in the space allowed. Fill in bubbles completely as indicated here: Erase changes cleanly. Do not fold form.

Patient Name: \_\_\_\_\_

MO	DAY	YEAR	DR#	PATIENT NUMBER																
1	7	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2	8	2	10	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
3	9	3	20	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
4	10	4	30	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
5	11	5	40	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
6	12	6	50	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
		10	7	60	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
		20	8	70	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7
		30	9	80	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
		90	9	90	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9

## A. PATIENT INFORMATION

Marital Status:

- Single
- Married
- Separated
- Divorced
- Widowed

Sex:

- M
- F

Patient Lives With:

- Alone
- Spouse
- Children
- Other
- Parents
- Roomate(s)
- Assisted Living

Children:

- 0  1  2  3  4  5

## B. PATIENT'S COMPLAINTS

1. Mark Your Present Complaints Below

Physical Examination with no complaints

### Neck / Back

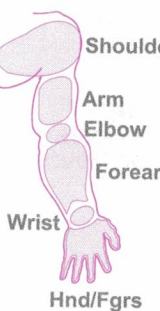


			Same As Left	Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Severity			Quality			Frequency			Trend							
											Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
Neck	Left		P	N	T	S	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Right		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
Upr Back	Left		P	N	T	S	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Right		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
Mid Back	Left		P	N	T	S	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Right		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
Low Back	Left		P	N	T	S	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Right		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
Ribs	Left		P	N	T	S	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Right		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R

When Did Your Neck/Back Complaints Begin?

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### Upper Extremities



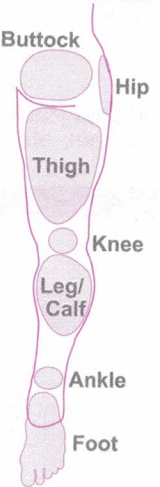
			Same As Above	Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Severity			Quality			Frequency			Trend							
											Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
LEFT	Shoulder		P	N	T	S	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Arm		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Elbow		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Forearm		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Wrist		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Hnd/Fgrs		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
RIGHT	Shoulder		P	N	T	S	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Arm		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Elbow		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Forearm		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Wrist		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Hnd/Fgrs		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R

When Did Your Upper Extremity Complaints Begin?

Same Date As Neck/Back

Different Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### Lower Extremities



			Same As Above	Pain	Numbness	Tingling	Stiffness	Soreness	Swelling	Weakness	Severity			Quality			Frequency			Trend							
											Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
LEFT	Hip		P	N	T	S	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Buttock		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Thigh		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Knee		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Leg/Calf		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Ankle		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
RIGHT	Hip		P	N	T	S	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Buttock		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Thigh		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Knee		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Leg/Calf		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R
	Ankle		S	P	N	T	S	S	S	W	M	M	S	B	D	S	S	A	T	O	I	F	C	I	W	U	R

When Did Your Lower Extremity Complaints Begin?

Same Date As Neck/Back

Different Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_



## B. PATIENT'S COMPLAINTS (CONTINUED)

### 2. How Did Your Complaint(s) Begin[1]?

- Unknown  Suddenly  Gradually

### 3. What Happened To Cause Or Re-Aggravate Your Complaint(s)?

- Cause Not Known  Auto Accident  
 Work Accident/Injury  Home Accident  
 Personal Injury  Sport Injury

Other - Describe: \_\_\_\_\_

### 4. How Would You Rate Your Overall Pain Today Where 0 Is No Pain And 10 Is The Worst Pain[1]?

No Pain  0  1  2  3  4  5  6  7  8  9  10 Worst Pain Possible

### 5. When Are Your Symptoms Worse?

- Morning  Afternoon  Evening  Night  
 Always The Same

### 6. What Makes Your Condition Better?

- Nothing  Stretching  Heat  
 Rest  Exercise  Ice  
 Sitting  Standing  Medications  
 Other

### 7. What Makes Your Condition Worse?

- Nothing  Coughing  Reaching  Standing  
 Sneezing  Lifting  Sitting  Pulling  
 Bending  Walking  Straining at Stool  Turning  
 Other

### 8. Have Any Of Your Complaint(s) Existed In The Past? Yes No

If Yes, Indicate Below

- Neck  Upr Back  Mid Back  Low Back  Ribs  
 Shoulder  Arm  Elbow  Forearm  Wrist  Hnd/fgrs  
 Buttock  Hip  Thigh  Knee  Leg/calf  Ankle  
 Foot  Others: \_\_\_\_\_

### 9. Have You Had Any Recent Treatment For Your Conditions OUTSIDE Of This Office[1]?

Yes  No If Yes, List Dates, Treatments, And Doctors.

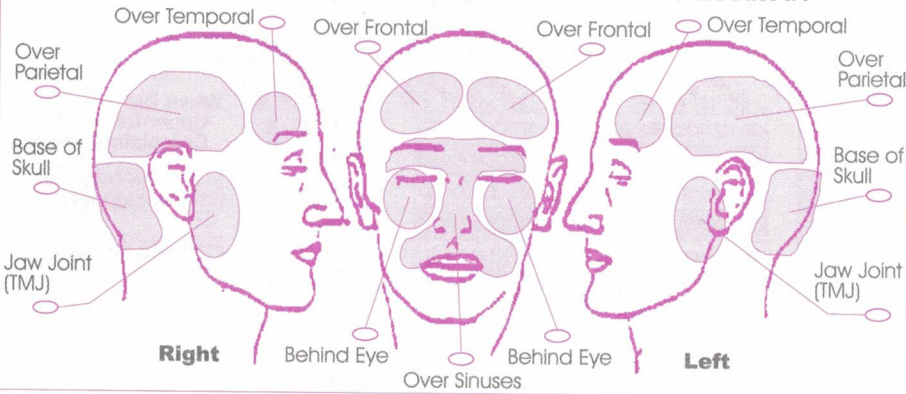
### 10. Since Your Symptoms Began, Have You Noticed A Change In?

Bowel Function	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> No To All
Bladder Function	<input type="radio"/> Yes	<input type="radio"/> No	
Sexual Function	<input type="radio"/> Yes	<input type="radio"/> No	

## C. HEADACHES

If You Are Experiencing Headaches, Please Fill Out This Section Otherwise Skip To Section D.

### 1. Where is The Pain Associated With Your Headaches Located?



### 6. What Seems To Bring On Your Headaches?

- Physical Activity  Caffeine  
 Excessive Stress  Certain Foods  
 Alcohol  Menstrual Period  
 Other

### 7. How Often Do They Occur[1]?

Times/Week:  1  2  3  4  5  6  7  8  9  
 Times/Month:  1  2  3  4  5  6  7  8  9  
 Other

### 8. How Long Do Your Headaches Last[1]?

- Less Than 1 Hour  From 1-3 Hours  
 Longer Than 3 Hours  All Waking Hours  
 Several Hours To Days  
 Other

### 2. On What Date Did Your Headaches Begin[1]?

Date: \_\_\_ / \_\_\_ / \_\_\_  Same As Neck/Back Complaints

### 3. How Does The Intensity Of Your Headaches Rate[1]?

No Pain  0  1  2  3  4  5  6  7  8  9  10 Worst Pain Possible

### 4. What Describes Your Pain?

- Dull  Sharp  Aching  Stabbing  
 Deep  Vice-Like  Burning  Throbbing/Pulsating  
 Other

### 5. When Do Your Headaches Usually Start?

- Constant/Anytime Awake  Wake Up With In Morning  
 At Midday  During Evening

### 9. Do Your Headaches Wake You From Sleep[1]?

- No  Sometimes  Always

### 10. Do Any Of The Following Occur With Your Headaches?

- Nausea/Vomiting  Weakness  
 Tremor  Vision Problems  
 Dizziness  Light/Sound Sensitivity  
 Other

### 11. What Makes Your Headaches Better?

- Nothing  Rest  Lying Down  Ice/Cold Packs  
 Massage  Standing  NSAIDS (Aspirin, Tylenol, etc.)  
 Other

## D. OTHER COMPLAINTS

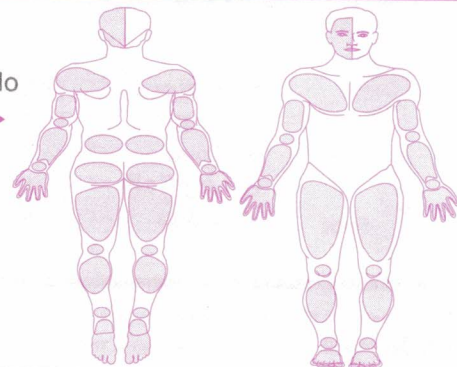
Do you have any other complaints not covered on this form[1]?  Yes  No

If Yes, Describe other complaints in detail and mark body areas on Figures. →

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





# HEALTH QUESTIONNAIRE-HISTORY F. HABITS/ACTIVITIES

Patient's Name

## E. REVIEW OF SYSTEMS

Are You Currently Suffering From Any Of The Symptoms Listed Below? If This Is A Re-Examination Mark Only New Symptoms Since Your Last Exam.

**None** Of The Symptoms Listed Below       **No New** Symptoms Since Your Last Exam

- | <input type="radio"/> General Fatigue  | <input type="radio"/> Skin Rash                    |   |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
|--|--|---|-------|-----------------|-----------------------|-----------------------|-----------------|-----------------------|-----------------------|--------------|-----------------------|-----------------------|---------------|-----------------------|-----------------------|----------------|-----------------------|-----------------------|--------------|-----------------------|-----------------------|---------------|-----------------------|-----------------------|--|
| <input type="radio"/> Weakness   | <input type="radio"/> Redness Of Skin              |   |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Fever (continuous)   | <input type="radio"/> Skin Itching                 |   |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Loss Of Sleep  | <input type="radio"/> Skin Dryness                 |   |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Chills (continuous)  | <input type="radio"/> Eczema(red, inflamed skin)   |   |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Weight Change (unplanned)  | <input type="radio"/> Hair Changes (unplanned)     |   |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Night Sweats   | <input type="radio"/> Nail Changes (unplanned)     |   |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Headaches  | <input type="radio"/> Bruise Easily                |   |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Dizziness  | <input type="radio"/> Cough (chronic)              |   |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Fainting   | <input type="radio"/> Wheezing (chronic)           |   |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Convulsions  | <input type="radio"/> Difficulty Breathing         |   |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Nervousness  | <input type="radio"/> Swollen Extremities          |   |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Anxiety  | <input type="radio"/> Blue Extremities             |   |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Depression (prolonged)   | <input type="radio"/> Varicosities (visible veins) |   |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Phobias (excessive fears)  | <input type="radio"/> Rapid Heart Beat             |   |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Memory Loss Or Impairment  | <input type="radio"/> Chest Pain                   |   |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Mood Swings (excessive)  | <input type="radio"/> Heart Palpitations           |   |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
|  | <input type="radio"/> Heart Murmur                 |   |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <table border="1"> <thead> <tr> <th></th> <th>Left</th> <th>Right</th> </tr> </thead> <tbody> <tr> <td>Hearing Trouble</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Ringing in Ears</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Pain in Ears</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Ear Discharge</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Vision Trouble</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Pain in Eyes</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Eye Discharge</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </tbody> </table> |  | Left  | Right | Hearing Trouble | <input type="radio"/> | <input type="radio"/> | Ringing in Ears | <input type="radio"/> | <input type="radio"/> | Pain in Ears | <input type="radio"/> | <input type="radio"/> | Ear Discharge | <input type="radio"/> | <input type="radio"/> | Vision Trouble | <input type="radio"/> | <input type="radio"/> | Pain in Eyes | <input type="radio"/> | <input type="radio"/> | Eye Discharge | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> Decreased Appetite |
|  | Left   | Right   |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| Hearing Trouble  | <input type="radio"/>                              | <input type="radio"/>                           |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| Ringing in Ears  | <input type="radio"/>                              | <input type="radio"/>                           |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| Pain in Ears   | <input type="radio"/>                              | <input type="radio"/>                           |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| Ear Discharge  | <input type="radio"/>                              | <input type="radio"/>                           |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| Vision Trouble   | <input type="radio"/>                              | <input type="radio"/>                           |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| Pain in Eyes   | <input type="radio"/>                              | <input type="radio"/>                           |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| Eye Discharge  | <input type="radio"/>                              | <input type="radio"/>                           |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
|  |  | <input type="radio"/> Increased Appetite        |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Nose/Sinus Pain  |  | <input type="radio"/> Abdominal Pain            |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Excessive Drainage   |  | <input type="radio"/> Hemorrhoids               |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Nose Bleeds (chronic)  |  | <input type="radio"/> Excess Gas                |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Nasal Infections (chronic)   |  | <input type="radio"/> Vomiting (excessive)      |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Absence Of Smell   |  | <input type="radio"/> Diarrhea (excessive)      |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Mouth Sores  |  | <input type="radio"/> Constipation (excessive)  |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Bleeding Gums  |  | <input type="radio"/> Heartburn/Indigestion     |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Enlarged Glands  |  | <input type="radio"/> Painful Urination         |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Absence Of Taste   |  | <input type="radio"/> Inability To Hold Urine   |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Abnormal Taste Sensation   |  | <input type="radio"/> Frequent Urination        |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Tonsillitis/Infected Tonsils   |  | <input type="radio"/> Urinary Retention         |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Difficulty With Swallowing   |  | <input type="radio"/> Bed-wetting               |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Heat/Cold Intolerance  |  | <input type="radio"/> Irregular Menstruation    |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Sugar In Urine   |  | <input type="radio"/> Painful Menstruation      |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Goiter (enlarged Thyroid gland)  |  | <input type="radio"/> Abnormal Vaginal Bleeding |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
| <input type="radio"/> Tremor (shaking)   |  | <input type="radio"/> Sterility                 |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
|  |  | <input type="radio"/> Impotence                 |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
|  |  | <input type="radio"/> Lumps In Breast(s)        |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
|  |  | <input type="radio"/> Redness/Itching of Breast |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
|  |  | <input type="radio"/> Dimpling of Breast(s)     |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
|  |  | <input type="radio"/> Discharge from Breast(s)  |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |
|  |  | <input type="radio"/> Breast Pain               |       |                 |                       |                       |                 |                       |                       |              |                       |                       |               |                       |                       |                |                       |                       |              |                       |                       |               |                       |                       |  |

Other (Please Describe)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**What Are Your Current Habits?**

Smoking.....  Never     <1     1-2     2-3     3-4     5+    Packs Per Day

Caffeinated Drinks.....  Never     <1     1-2     2-3     3-4     5+    Glasses Per Day

Alcohol Consumption.....  Never     <1     1-2     2-3     3-4     5+    Glasses Per Day

Drug/Substance Abuse..  No     Yes    If Yes, Discuss With Doctor

Exercise.....  Never     <1     1-2     2-3     3-4     5+    Days Per Week

Kinds Of Exercise You Do:

Walking     Jogging     Cycling     Swimming

Golf     Tennis     Strength Training

Other: \_\_\_\_\_

## G. MEDICAL HISTORY

### 1. HEALTH CARE

a. Have You Ever Been To A Chiropractor? . . . . .  Yes     No

b. Do You Have A Family Physician . . . . .  Yes     No

Date Of Last Physical Exam: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

c. Have You Been Hospitalized In The Past? . . . . .  Yes     No

Date & Reason For Hospitalization: \_\_\_\_\_

d. Have You Ever Had Surgery? . . . . .  Yes     No

Date, Reason, Results Of Surgery: \_\_\_\_\_

e. Have You Ever Had A Serious Accident/Injury?  Yes     No

List Date & Describe Injury:

Auto: \_\_\_\_\_

Work-Related: \_\_\_\_\_

Personal: \_\_\_\_\_

Sports Injury: \_\_\_\_\_

Other: \_\_\_\_\_

f. Are You Currently Taking Any Vitamins, Minerals, Or Herbs? (List Supplements)     Yes     No

\_\_\_\_\_

g. Are You Currently Taking Any Medications?  Yes     No

For What Condition(s) Are You Taking Medication?

Anti-inflammatory (Aspirin, Ibuprofen, Motrin, etc.): \_\_\_\_\_

Pain/Analgesics: \_\_\_\_\_

Anti-Depressants: \_\_\_\_\_

Muscle Relaxants: \_\_\_\_\_

Blood Pressure Pills: \_\_\_\_\_

Antibiotics: \_\_\_\_\_

Birth Control Pills: \_\_\_\_\_

Corticosteroid: \_\_\_\_\_

Other: \_\_\_\_\_

**In The Past Have You Use Any Of The Following?**

Birth Control Pills     Corticosteroid

h. Are You Allergic To Any Medications? . . . . .  Yes     No

List Medications: \_\_\_\_\_



### G. MEDICAL HISTORY - CONTINUED

#### 1i. WOMEN ONLY:

To Your Knowledge, **Are You Pregnant?**

If Pregnant In Past, Were Pregnancies Normal?

Are You Seeing An OB-GYN Regularly?

Number Of Births:  1  2  3  4  5  Other: \_\_\_\_\_

Date Of Last Exam: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

Yes	No
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>

#### 2. FAMILY HISTORY

	Cancer	Diabetes	Heart Trouble	High Blood Pres	Stroke	Kidney Disease	Anemia	Mental Illness	Headaches	Osteoporosis	Arthritis	Joint Problems	Scoliosis	Back Problems	Disc Problems	Congenital Defects	Other	Deceased?
Father	<input type="radio"/> C <input type="radio"/> D <input type="radio"/> H <input type="radio"/> S <input type="radio"/> K <input type="radio"/> A <input type="radio"/> M <input type="radio"/> H <input type="radio"/> O <input type="radio"/> A <input type="radio"/> J <input type="radio"/> S <input type="radio"/> P <input type="radio"/> D <input type="radio"/> G <input type="radio"/> O <input type="radio"/> D																	
Mother	<input type="radio"/> C <input type="radio"/> D <input type="radio"/> H <input type="radio"/> S <input type="radio"/> K <input type="radio"/> A <input type="radio"/> M <input type="radio"/> H <input type="radio"/> O <input type="radio"/> A <input type="radio"/> J <input type="radio"/> S <input type="radio"/> P <input type="radio"/> D <input type="radio"/> G <input type="radio"/> O <input type="radio"/> D																	
Brothers	<input type="radio"/> C <input type="radio"/> D <input type="radio"/> H <input type="radio"/> S <input type="radio"/> K <input type="radio"/> A <input type="radio"/> M <input type="radio"/> H <input type="radio"/> O <input type="radio"/> A <input type="radio"/> J <input type="radio"/> S <input type="radio"/> P <input type="radio"/> D <input type="radio"/> G <input type="radio"/> O																	
Sisters	<input type="radio"/> C <input type="radio"/> D <input type="radio"/> H <input type="radio"/> S <input type="radio"/> K <input type="radio"/> A <input type="radio"/> M <input type="radio"/> H <input type="radio"/> O <input type="radio"/> A <input type="radio"/> J <input type="radio"/> S <input type="radio"/> P <input type="radio"/> D <input type="radio"/> G <input type="radio"/> O																	
Children	<input type="radio"/> C <input type="radio"/> D <input type="radio"/> H <input type="radio"/> S <input type="radio"/> K <input type="radio"/> A <input type="radio"/> M <input type="radio"/> H <input type="radio"/> O <input type="radio"/> A <input type="radio"/> J <input type="radio"/> S <input type="radio"/> P <input type="radio"/> D <input type="radio"/> G <input type="radio"/> O																	

Describe Others: \_\_\_\_\_

#### 3. Conditions Or Illnesses

Please Indicate If You Now Have or Have Had In The Past Any Of The Following Illnesses:

No Current Or Previous Conditions/Illnesses

<b>Now Have</b>	<b>In Past</b>	<b>Now Have</b>	<b>In Past</b>
<input type="radio"/> Sinus Trouble	<input type="radio"/> Sinus Trouble	<input type="radio"/> Kidney Trouble	<input type="radio"/> Kidney Trouble
<input type="radio"/> Hay Fever	<input type="radio"/> Hay Fever	<input type="radio"/> Urinary Retention	<input type="radio"/> Urinary Retention
<input type="radio"/> Allergies	<input type="radio"/> Allergies	<input type="radio"/> Frequent Urination	<input type="radio"/> Frequent Urination
<input type="radio"/> Asthma	<input type="radio"/> Asthma	<input type="radio"/> Prostate Trouble	<input type="radio"/> Prostate Trouble
<input type="radio"/> Emphysema	<input type="radio"/> Emphysema	<input type="radio"/> Arthritis	<input type="radio"/> Arthritis
<input type="radio"/> Tuberculosis	<input type="radio"/> Tuberculosis	<input type="radio"/> Osteoporosis	<input type="radio"/> Osteoporosis
<input type="radio"/> History of Infection	<input type="radio"/> History of Infection	<input type="radio"/> Scoliosis	<input type="radio"/> Scoliosis
<input type="radio"/> Fever (Continuous)	<input type="radio"/> Fever (Continuous)	<input type="radio"/> Dislocated Joints	<input type="radio"/> Dislocated Joints
<input type="radio"/> Cancer/Tumor	<input type="radio"/> Cancer/Tumor	<input type="radio"/> Spinal Disc Disease	<input type="radio"/> Spinal Disc Disease
<input type="radio"/> Diabetes	<input type="radio"/> Diabetes	<input type="radio"/> Bone Fracture (list/dates):	<input type="radio"/> Bone Fracture (list/dates):
<input type="radio"/> Visual Disturbances	<input type="radio"/> Visual Disturbances		
<input type="radio"/> Dizziness/Fainting	<input type="radio"/> Dizziness/Fainting		
<input type="radio"/> Epilepsy/Seizures	<input type="radio"/> Epilepsy/Seizures		
<input type="radio"/> Thyroid Trouble	<input type="radio"/> Thyroid Trouble	<input type="radio"/> Mental/Emotional Difficulty	<input type="radio"/> Mental/Emotional Difficulty
<input type="radio"/> High Blood Pressure	<input type="radio"/> High Blood Pressure	<input type="radio"/> Sex. Trans. Diseases	<input type="radio"/> Sex. Trans. Diseases
<input type="radio"/> Low Blood Pressure	<input type="radio"/> Low Blood Pressure	<input type="radio"/> HIV	<input type="radio"/> HIV
<input type="radio"/> Heart Trouble	<input type="radio"/> Heart Trouble	<input type="radio"/> AIDS/ARC	<input type="radio"/> AIDS/ARC
<input type="radio"/> Pacemaker	<input type="radio"/> Pacemaker	<input type="radio"/> Abnormal Weight Gain	<input type="radio"/> Abnormal Weight Gain
<input type="radio"/> Stroke [date _____]	<input type="radio"/> Stroke [date _____]	<input type="radio"/> Abnormal Weight Loss	<input type="radio"/> Abnormal Weight Loss
<input type="radio"/> Aortic Aneurysm	<input type="radio"/> Aortic Aneurysm	<input type="radio"/> Numbness Groin/Buttocks	<input type="radio"/> Numbness Groin/Buttocks
<input type="radio"/> Anemia	<input type="radio"/> Anemia	<input type="radio"/> Other: _____	<input type="radio"/> Other: _____
<input type="radio"/> Rheumatic Fever	<input type="radio"/> Rheumatic Fever		
<input type="radio"/> Polio	<input type="radio"/> Polio		
<input type="radio"/> Multiple Sclerosis	<input type="radio"/> Multiple Sclerosis	<input type="radio"/> Other: _____	<input type="radio"/> Other: _____
<input type="radio"/> Ulcer	<input type="radio"/> Ulcer		
<input type="radio"/> Liver Trouble	<input type="radio"/> Liver Trouble		

### H. OCCUPATIONAL INFORMATION - ACTIVITIES OF DAILY LIVING

1. Are You Right Or Left Handed?  Right  Left

#### 2. Job Type

Retired  Unemployed  Full-Time Student

**If Any Of Above Skip Rest, Sign At Patient's Signature**

Full Time  Part Time  Temporary

Self-Employed  Other \_\_\_\_\_

#### 3. During Your Work Week, You Work How Many:

Hours Per Day  1  2  3  4  5  6  7  8  9  10  11  12

Days Per Week  1  2  3  4  5  6  7

Other \_\_\_\_\_

#### 4. How Long Have You Been With Your Present Employer?

Years  10  20  30  40  50

1  2  3  4  5  6  7  8  9

Months  1  2  3  4  5  6  7  8  9  10  11

5. Do Your Present Complaints Affect The Number Of Hours You Work Per Day?  Yes  No

#### 6. What Is Your Primary Work Position and Location?

a. Work Position:  Seated  Standing  Desk  Counter  Workbench  Other \_\_\_\_\_

b. Work Location:  Other \_\_\_\_\_

#### 7. What Movements Does Your Job Require?

Bending  Turning  Stooping

Twisting  Walking  Repetitive Hand Use

Carrying  Other \_\_\_\_\_

#### 8. Does Your Work Include Any Of The Following Use?

Prolonged Computer  Continuous Phone

#### 9. Does Your Job Involve Lifting?

Never  Occasionally  Intermittently

Frequently  Constantly

How Many Pounds?  10  20  30  40  50  60  70  80  90  100+ Pounds

(Choose Only One)

#### 10. What Best Describes Your Stress Level At Work?

None  Minimal  Minimal To Moderate

Moderate  Moderate To Extreme  Extreme

#### 11. How Do You Rate Your Physical Activity At Work?

Seated more than 50% of workday

Manual Labor:  Light  Light To Moderate

Moderate  Moderate To Heavy  Heavy

#### 12. Do Work Activities Aggravate Your Present Complaints?

Yes  No If Yes, Explain: \_\_\_\_\_

PATIENT'S SIGNATURE

DATE: