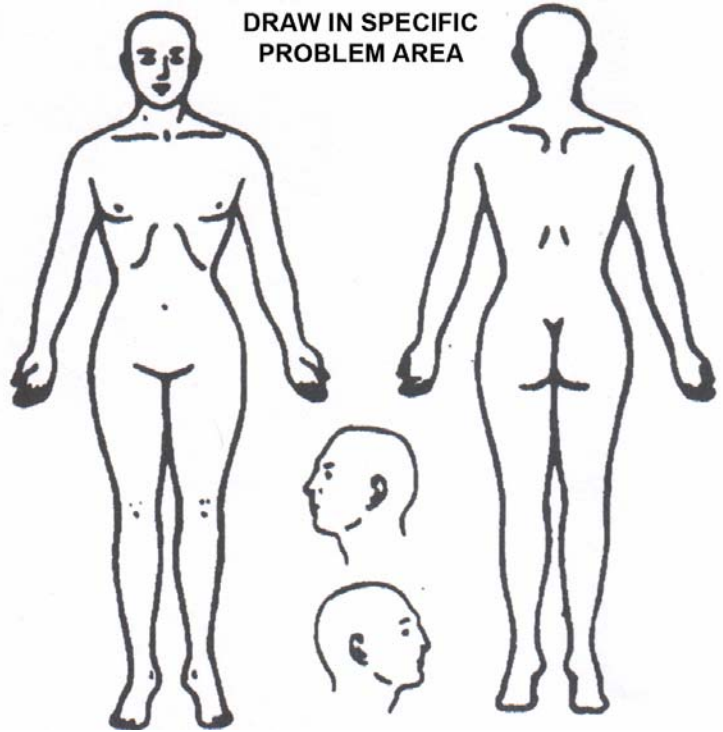


COMPREHENSIVE HEALTH QUESTIONNAIRE

**Instructions: Please answer the following questions... Yes, if you have Or have had problems
No, if you have never had a problem**

- Do you exercise regularly? Yes ___ No ___
 Do you suffer from severe headaches? Yes ___ No ___
 Do you have convulsions or epilepsy? Yes ___ No ___
 Parts of your body ever paralyzed? Yes ___ No ___
 Were you ever knocked unconscious? Yes ___ No ___
 Do you have difficulty sleeping? Yes ___ No ___
 Do you smoke or drink excessively? Yes ___ No ___
 Do you drink a lot of coffee? Yes ___ No ___
 Do you have spells of exhaustion? Yes ___ No ___
 Do you get up tired in the morning? Yes ___ No ___
 Are you frequently ill? Yes ___ No ___
 Have you had any of the following within the last year?
 A. Complete physical examination Yes ___ No ___
 B. Heart examination Yes ___ No ___
 C. Blood pressure check Yes ___ No ___
 D. Medical care Yes ___ No ___
 E. Chiropractic care Yes ___ No ___
 Does arthritis run in your family? Yes ___ No ___
 Do you get up at night and urinate? Yes ___ No ___
 Do you black out or faint? Yes ___ No ___
 Is there constant noise in ears? Yes ___ No ___
 Do you have sinus problems? Yes ___ No ___
 Do you have allergies? Yes ___ No ___
 Do you cough up blood? Yes ___ No ___
 Do you have night sweats? Yes ___ No ___
 Pains in the heart or chest? Yes ___ No ___
 Difficulty in breathing? Yes ___ No ___
 Out of breath before anyone else? Yes ___ No ___
 Ankles badly swollen? Yes ___ No ___
 Suffer from cramps on your legs? Yes ___ No ___
 Do you have heart trouble? Yes ___ No ___
 Do you have badly coated tongue? Yes ___ No ___
 Do you eat sweets between meals? Yes ___ No ___
 Suffer from indigestion? Yes ___ No ___
 Double up from severe stomach pains? Yes ___ No ___
 Loose bowel movements? Yes ___ No ___
 Bad constipation? Yes ___ No ___
 Painful menstrual periods? Yes ___ No ___
 Severe hot flashes and sweats? Yes ___ No ___
 Recent and rapid weight loss? Yes ___ No ___

Height _____ Weight _____
 (Circle One)
 Activity Level: Sedentary - Active - Very Active
 Stress Level: Minimal - Moderate - Great



 P PAIN – CONSTANT OR FREQUENT (MAIN PROBLEM)
 C PAIN – OFF & ON, INFREQUENT OR CHRONIC
 N NUMBNESS, TINGLING OR BURNING

ADDITIONAL COMMENTS: _____

FAMILY HEALTH HISTORY RECORD

Name & Address	Date of Birth	HEALTH HISTORY	
		Past	Present
Husband Or Wife:			
Children:			
Mother:			
Father:			
Sisters: Brothers:			

IN CASE OF EMERGENCY, WHO CAN WE CALL OTHER THAN YOUR HOME?

Name _____ Address _____ Relationship _____ Home Phone _____ Work Phone _____
 Current Medical Doctor: _____ Phone No.: _____
 Which hospital would you prefer in case of an emergency? _____

PATIENT INTRODUCTION CARD

Date: _____ Patient # _____
Patient Name: Last: _____ First: _____ Init. _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: () _____ - _____ Birth Date: ____/____/____ Age: _____
Sex: (M-male, F-female): _____ Marital Status: M S W D Patient Soc. Sec. #: _____
Patient Employed By: _____
Occupation: _____ Business Phone: () _____
Referred by: _____
Briefly Describe Chief Complaint (Symptoms): _____

How did it happen? _____

How would you rate your pain today ("0" being no pain and "10" being the worst pain)? _____

What have you done to try to help this problem so far? _____

Have you ever had same or similar complaint? Yes or No Explain: _____

List all other health problems and symptoms you are having: _____

List all past surgeries: _____

List all medications you are currently taking: _____ for _____ for _____

_____ for _____ for _____ for _____

Have you been to a chiropractor before? Yes or No If Yes, for what? _____

FEMALES ONLY: To your knowledge, are you pregnant? Yes or No (Circle One)

Are you claiming Workman's Compensation? Yes _____ No _____

Are you claiming Auto Accident? Yes _____ No _____

Company or Insurance Name: _____

Address: _____ Phone #: () _____

Attorney Name and Phone #: _____

- I am interested in Only Symptomatic Relief (Feel Better)
- I am interested in Symptomatic Relief, and Maximum Correction of My Problem
- I am interested in Symptomatic Relief, and Maximum Correction and a Health Maintenance Plan

DO YOU HAVE ANY PROBLEMS WITH THE FOLLOWING

PRESENT PAST

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Bladder trouble |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hay fever | <input type="checkbox"/> T. B. | <input type="checkbox"/> Menstrual cramps, pain |
| <input type="checkbox"/> Arteriole sclerosis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Menstrual irregularity |
| <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tightness of throat | <input type="checkbox"/> Heart attacks | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Cervical arthritis | <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Chest and left arm pain | <input type="checkbox"/> Painful joints |
| <input type="checkbox"/> Recent severe neck strain | <input type="checkbox"/> Face flushed | <input type="checkbox"/> Anemia | <input type="checkbox"/> Swollen joints |
| <input type="checkbox"/> Family history of strokes | <input type="checkbox"/> Twitching of face | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Dizziness or unsteadiness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nervous stomach | <input type="checkbox"/> Slipped disc |
| <input type="checkbox"/> Fainting or lightheadedness | <input type="checkbox"/> Depression | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Ruptured disc |
| <input type="checkbox"/> Temporary loss of memory | <input type="checkbox"/> Head feels too heavy | <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Previous disc surgery |
| <input type="checkbox"/> Numbness in face or arms | <input type="checkbox"/> Muscle spasm in neck | <input type="checkbox"/> Nerves, nervousness | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Garbled speech | <input type="checkbox"/> Increased pain to cough, sneeze | <input type="checkbox"/> Inner tension | <input type="checkbox"/> Pinched nerves in back |
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Grating in neck | <input type="checkbox"/> Irritability | <input type="checkbox"/> Leg pain |
| <input type="checkbox"/> Recent severe, sudden head pain | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Liver trouble | <input type="checkbox"/> Numbness in legs |
| <input type="checkbox"/> Chronic headaches | <input type="checkbox"/> Tightness of shoulder muscles | <input type="checkbox"/> Gall bladder trouble | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Pins & needles in arms, hands | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Intestinal gas | <input type="checkbox"/> Pains in legs and feet |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Constipation | |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Kidney trouble | |

ANY FALLS, ACCIDENTS, INJURIES? Yes No

If yes, please explain: _____

Please specify the doctor of your choice: _____

PLEASE RETURN THIS FORM WITH OUR INSURANCE CARD TO FRONT DESK