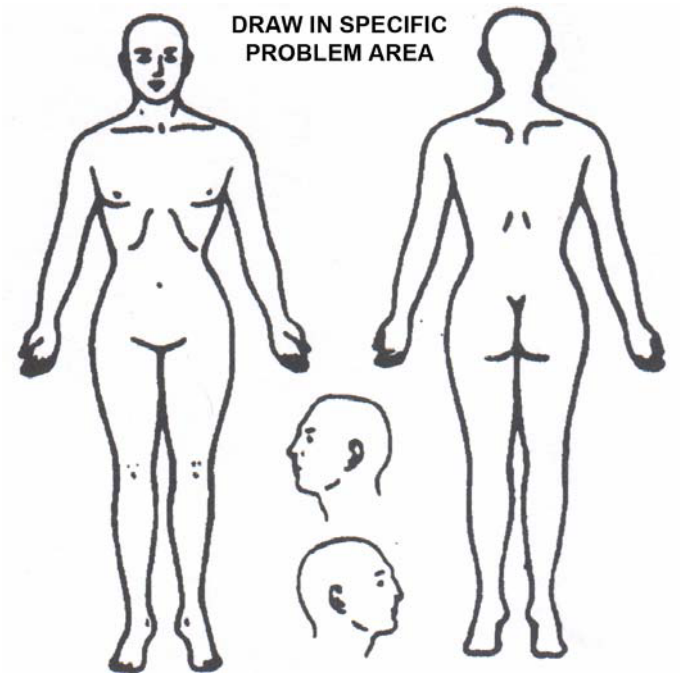
COMPREHENSIVE HEALTH QUESTIONNAIRE

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 ____
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 get up tired in the morning?	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 have night sweats?	Yes ____	No ____
Pains in the heart or chest?	Yes ____	No ____
Difficulty iin breathing?	Yes ____	No ____
Ankles badly swollen?	Yes ____	No ____
Suffer from cramps on your legs?	Yes ____	No ____
Do you have heart trouble?	Yes ____	No ____
Suffer from indigestion?	Yes ____	No ____
Loose bowel movements?	Yes ____	No ____
Bad constipation?	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: _____

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? _____ When 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 #: _____

DO YOU HAVE ANY PROBLEMS WITH THE FOLLOWING ☒ PRESENT ☐ PAST

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

ANY FALLS, ACCIDENTS, INJURIES? ☐ Yes ☐ No

If yes, please explain: _____

_____

Please specify the doctor of your choice: _____

PLEASE RETURN THIS FORM WITH YOUR INSURANCE CARD TO FRONT DESK