COMPREHENSIVE HEALTH QUESTIONNAIRE

Instructions: Please answer the following questions... <u>Yes</u>, if you have <u>Or</u> have had problems

<u>Yes</u>, if you have <u>Or</u> have had problems <u>No</u>, if you have never had a problem

Do you exercise regularly?	Yes	No	Height	Weight
Do you suffer from severe headaches?	Yes	No	(Circle One)	
Do you have convulsions or epilepsy?	Yes	No	Activity Level: Stress Level:	Sedentary - Active - Very Active Minimal - Moderate - Great
Were you ever knocked unconscious?	Yes	No		
Do you have difficulty sleeping?	Yes	No	6	DRAW IN SPECIFIC
Do you smoke or drink excessively?	Yes	No	(3)	PROBLEM AREA
Do you drink a lot of coffee?	Yes	No	عر	
Do you get up tired in the morning?	Yes	No	-	
Have you had any of the following				
within the last year?			IN	$\langle \mathcal{I} \rangle \langle \mathcal{I} \rangle \langle$
A. Complete physical examination	Yes	No	$(1)^{r}$.	
B. Heart examination	Yes	No)(]	
C. Blood pressure check	Yes	No	E T	
D. Medical care	Yes	No		$1 \cap 11$
E. Chiropractic care	Yes	No		
Does arthritis run in your family?	Yes	No	1.1	
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) (11 183 1241
Do you have sinus problems?	Yes	No	4	J F UU
Do you have allergies?	Yes	No		
Do you have night sweats?	Yes	No		
Pains in the heart or chest?	Yes	No	P PAIN	- CONSTANT OR FREQUENT (MAIN PROBLEM)
Difficulty iin breathing?	Yes	No		
Ankles badly swollen?	Yes	No	<u> </u>	– OFF & ON, INFREQUENT OR CHRONIC
Suffer from cramps on your legs?	Yes	No	N NUM	BNESS, TINGLING OR BURNING
Do you have heart trouble?	Yes	No		
Suffer from indigestion?	Yes	No	ADDITIONAL C	COMMENTS:
Loose bowel movements?	Yes	No		
Bad constipation?	Yes	No		
Severe hot flashes and sweats?	Yes	No		
Recent and rapid weight loss?	Yes	No		

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

Name	Address	Relationship	Home Phone	Work Phone
Current Me	dical Doctor:	_	Phone No.:	
Which hosp	ital would you prefer in	case of an emergency?		

PATIENT INTRODUCTION CARD

					Patient			
Patient Name: Last:			First:					Init.
Address:					State			Zip:
Phone: ())ate.	1	/	
Sex: (M-male, F-female):		· M C		Patient So				
				r alient So				
Patient Employed By:			D					
Occupation:			Busines	s Phone: ()			
Referred by:								
Briefly Describe Chief Complaint (Sympton)								
How did it happen?								
How would you rate your pain today (0 b	peing no pain and 10 be	ing the	worst pa	in)?				
What have you done to try to help this p								
Have you ever had same or similar com								
List all other health problems and sympt								
	onis you are naving							
_ist all past surgeries:								
List all medications you are currently tak								•
								•
Have you been to a chiropractor before?	? Yes or No If Ye	es, for w	/hat?					
FEMALES ONLY: To your knowledge, a	are you pregnant? Yes	or No	o (Circle	e One)				
Are you claiming Workman's Compensa	ition?	Yes		, 	No			
Are you claiming Auto Accident?					No			
Company or Insurance Name:								
Address:			Dhone t	4· ()				
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Attorney Name and Phone #:								
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Attorney Name and Phone #: DO YOU H.	AVE ANY PROBLEMS			LOWING 🛛	PRESENT	D P		uble
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Attorney Name and Phone #: DO YOU H. Low blood pressure High blood pressure Arteriole sclerosis Cardiovascular disease Diabetes	AVE ANY PROBLEMS	WITH 1		LOWING Description Cold hands Bursitis Cold sweat T. B. Chest pain	PRESENT	D P	AST Kidney tro Bladder tr Menstrual Menstrual Cancer	uble ouble cramps, pain irregularity
Attorney Name and Phone #: DO YOU H. Low blood pressure High blood pressure Arteriole sclerosis Cardiovascular disease Diabetes Cervical arthritis	AVE ANY PROBLEMS Sinus trouble Loss of balance Loss of smell Hay fever Tightness of throat Thyroid trouble	WITH 1		LOWING Description Cold hands Bursitis Cold sweat T. B. Chest pain Chest pain Chest and	PRESENT	D P	AST Kidney tro Bladder tri Menstrual Menstrual Cancer Painful join	uble ouble cramps, pain irregularity nts
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Attorney Name and Phone #: DO YOU H. Low blood pressure High blood pressure Arteriole sclerosis Cardiovascular disease Diabetes Cervical arthritis Recent severe neck strain Family history of strokes	AVE ANY PROBLEMS	WITH 1		LOWING Description Cold hands Bursitis Cold sweat T. B. Chest pain Chest pain Chest and Anemia Rheumatic	PRESENT s left arm pain Fever	D P	AST Kidney tro Bladder tri Menstrual Menstrual Cancer Painful join Swollen jo Sipped di	uble ouble cramps, pain irregularity nts ints sc
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Attorney Name and Phone #: DO YOU H. 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	AVE ANY PROBLEMS Sinus trouble Loss of balance Loss of smell Hay fever Tightness of throat Thyroid trouble Face flushed Twitching of face Fatigue Depression	WITH 1		LOWING Description Cold hands Bursitis Cold sweat T. B. Chest pain Chest and Anemia Rheumatic Nervous sta Ulcers	PRESENT s left arm pain Fever omach	<u> </u>	AST Kidney tro Bladder tr Menstrual Cancer Painful join Swollen jo Slipped di Ruptured Previous o	uble ouble cramps, pain irregularity nts ints sc disc disc surgery
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