

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/fgs
 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.

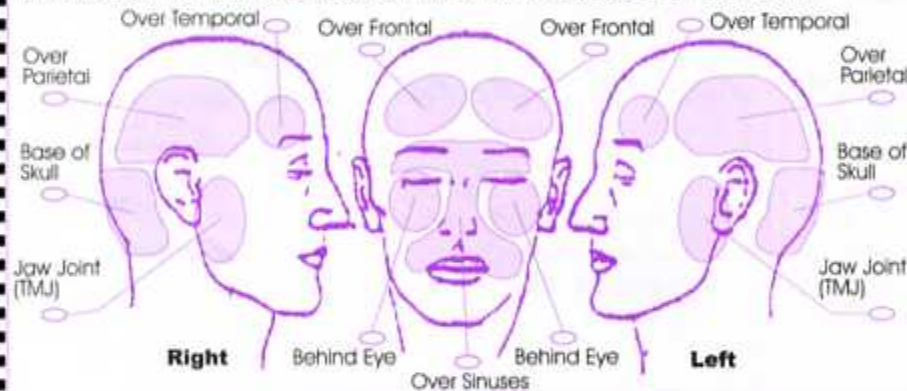
10. Since Your Symptoms Began, Have You Noticed A Change In?

- Bowel Function Yes No
 Bladder Function Yes No No To All
 Sexual Function Yes 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 10
 Times/Month: 1 2 3 4 5 6 7 8 9 10
 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

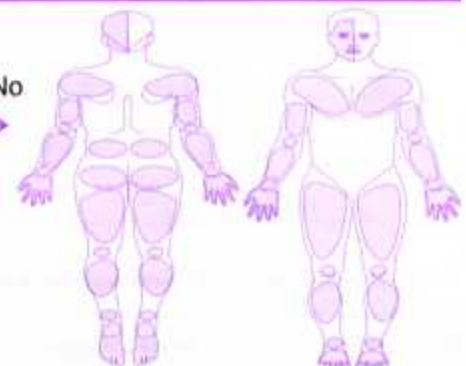
11. What Makes Your Headaches Better?

- 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

Patient's Name

F. HABITS/ACTIVITIES

What Are Your Current Habits?

Smoking..... **Never** **<1** **1-2** **2-3** **3-4** **5+**

Caffeinated Drinks..... **Never** **<1** **1-2** **2-3** **3-4** **5+**

Alcohol Consumption..... **Never** **<1** **1-2** **2-3** **3-4** **5+**

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

Exercise..... **Never** **<1** **1-2** **2-3** **3-4** **5+**

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:

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

- General Fatigue
 Weakness
 Fever (continuous)
 Loss Of Sleep
 Chills (continuous)
 Weight Change (unplanned)
 Night Sweats

- Headaches
 Dizziness
 Fainting
 Convulsions
 Nervousness

- Anxiety
 Depression (prolonged)
 Phobias (excessive fears)
 Memory Loss Or Impairment
 Mood Swings (excessive)

- | | 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"/> |

- | | Left | Right |
|----------------|-----------------------|-----------------------|
| 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"/> |

- Nose/Sinus Pain
 Excessive Drainage
 Nose Bleeds (chronic)
 Nasal Infections (chronic)
 Absence Of Smell

- Mouth Sores
 Bleeding Gums
 Enlarged Glands
 Absence Of Taste
 Abnormal Taste Sensation
 Tonsillitis/Infected Tonsils
 Difficulty With Swallowing

- Heat/Cold Intolerance
 Sugar In Urine
 Goiter (enlarged Thyroid gland)
 Tremor (shaking)

Other (Please Describe)

- Skin Rash
 Redness Of Skin
 Skin Itching
 Skin Dryness
 Eczema (red, inflamed skin)
 Hair Changes (unplanned)
 Nail Changes (unplanned)
 Bruise Easily

- Cough (chronic)
 Wheezing (chronic)
 Difficulty Breathing
 Swollen Extremities
 Blue Extremities
 Varicosities (visible veins)
 Rapid Heart Beat
 Chest Pain
 Heart Palpitations
 Heart Murmur

- Decreased Appetite
 Increased Appetite
 Abdominal Pain
 Hemorrhoids
 Excess Gas
 Vomiting (excessive)
 Diarrhea (excessive)
 Constipation (excessive)
 Heartburn/Indigestion

- Painful Urination
 Inability To Hold Urine
 Frequent Urination
 Urinary Retention
 Bed-wetting
 Irregular Menstruation
 Painful Menstruation
 Abnormal Vaginal Bleeding
 Sterility
 Impotence

- Lumps In Breast(s)
 Redness/Itching of Breast
 Dimpling of Breast(s)
 Discharge from Breast(s)
 Breast Pain

