

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	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
2	8	2	10	1	1	1	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	2	2	2
4	10	4	30	3	3	3	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	4	4	4
6	12	6	50	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
		10	60	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
		20	70	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7
		30	80	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
			90	9	9	9	9	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

Children: 0 1 2 3 4 5+

Patient Lives With: Alone Spouse Children Other Parents Roommate(s) Assisted Living

B. PATIENT'S COMPLAINTS 1. Mark Your Present Complaints Below Physical Examination with no complaints.

Neck / Back

			Neck/Back						Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved	When Did Your Neck/Back Complaints Begin?
			Same As Left	Pain	Numbness	Tingling	Stiffness	Soreness																		
Neck	Left		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date: _____ / _____ / _____	
	Right		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
Upr Back	Left		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date: _____ / _____ / _____	
	Right		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
Mid Back	Left		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date: _____ / _____ / _____	
	Right		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
Low Back	Left		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date: _____ / _____ / _____	
	Right		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
Ribs	Left		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date: _____ / _____ / _____	
	Right		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>

Upper Extremities

			Upper Extremities						Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved	When Did Your Upper Extremity Complaints Begin?	
			Same As Above	Pain	Numbness	Tingling	Stiffness	Soreness																			Swelling
LEFT	Shoulder		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date: _____ / _____ / _____	
	Arm		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
	Elbow		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
	Forearm		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
	Wrist		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
	Hnd/Fgrs		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
RIGHT	Shoulder		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date: _____ / _____ / _____	
	Arm		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
	Elbow		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
	Forearm		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
	Wrist		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
	Hnd/Fgrs		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>

Lower Extremities

			Lower Extremities						Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved	When Did Your Lower Extremity Complaints Begin?	
			Same As Above	Pain	Numbness	Tingling	Stiffness	Soreness																			Swelling
LEFT	Hip		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date: _____ / _____ / _____	
	Buttock		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
	Thigh		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
	Knee		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
	Leg/Calf		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
	Ankle		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
RIGHT	Hip		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Date: _____ / _____ / _____	
	Buttock		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
	Thigh		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
	Knee		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
	Leg/Calf		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
	Ankle		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>

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

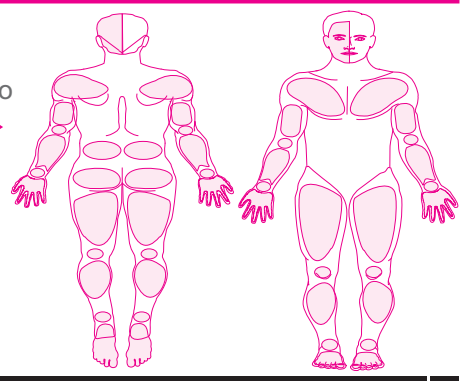
- 2. On What Date Did Your Headaches Begin[1]?**
 Date: ___ / ___ / ___ Same As Neck/Back Complaints
- 3. How Does The Intensity Of Your Headaches Rate[1]?**
 No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible
- 4. What Describes Your Pain?**
 Dull Sharp Aching Stabbing
 Deep Vice-Like Burning Throbbing/Pulsating
 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 NSAIDS (Aspirin, Tylenol, etc.) Rest
 Massage Lying Down Standing Ice/Cold Packs
 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

- 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"/>

- Vision Trouble
- Pain in Eyes
- Eye Discharge
- 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

F. HABITS/ACTIVITIES

What Are Your Habits?

Smoking..... Never None <1 1-2 2-3 3-4 5+

Caffeinated Drinks..... Never None <1 1-2 2-3 3-4 5+

Alcohol Consumption..... Never None <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: _____

G. MEDICAL HISTORY - CONTINUED

1i. WOMEN ONLY:

To Your Knowledge, Are You Pregnant? Yes No
If Pregnant In Past, Were Pregnancies Normal? Yes No
Are You Seeing An OB-GYN Regularly? Yes No
Number Of Births: 1 2 3 4 5 Other: _____
Date Of Last Exam: _____
Physician's Name: _____
Address: _____
 _____ Phone:() _____

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"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mother	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Brothers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sisters	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

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

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:

PLEASE MAKE NO MARKS IN THIS AREA

