

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.

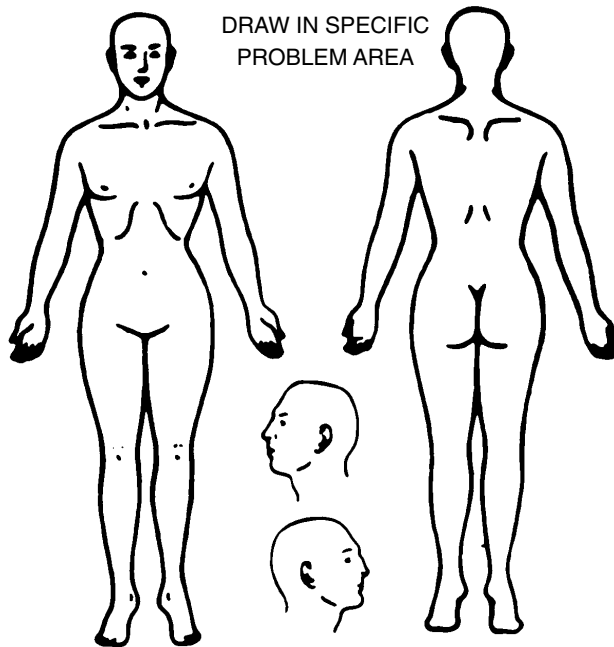
- DO YOU EXERCISE REGULARLY? YES ___ NO ___
- DO YOU SUFFER FROM SEVERE HEADACHES? YES ___ NO ___
- DO YOU HAVE CONVULSIONS OR EPILEPSY? YES ___ NO ___
- PARTS OF YOUR BODY EVER PARALYZED? YES ___ NO ___
- WERE YOU EVER KNOCKED UNCONSCIOUS? YES ___ NO ___
- DO YOU HAVE DIFFICULTY SLEEPING? YES ___ NO ___
- 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 ALLERGYS? 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	
		PREVIOUS YEARS	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 PH. _____ WORK H. _____

CURRENT MEDICAL DOCTOR? _____ PHONE # _____

WHICH HOSPITAL WOULD YOU PREFER IN CASE OF AN EMERGENCY? _____