

HEALTH QUESTIONNAIRE

Name: _____ Date: _____

In addition to your primary complaint(s), please list any other conditions you have or are being treated for: _____

What do you believe is wrong with you? _____

List any doctors being seen or previously seen for these conditions, the treatment administered and results:

Doctor	Condition	Treatment	Results

List all surgeries you have had and provide dates:

List all medications/supplements you are taking:

Please check the conditions you have or have had:

- | | | | | |
|---------------------------------------|--|--|---|---|
| <input type="checkbox"/> AIDS or HIV+ | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Cardiovascular Disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Osteoporosis |

Family History: Please check the conditions your family has or has had:

- | | | | | |
|---------------------------------------|--|--|---|---|
| <input type="checkbox"/> AIDS or HIV+ | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Cardiovascular Disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Osteoporosis |

Please check all present symptoms:

CARDIOVASCULAR:

- | | | | | |
|---|--|--|---|--|
| <input type="checkbox"/> swelling: _____ | <input type="checkbox"/> chest pain | <input type="checkbox"/> pounding heart beat | <input type="checkbox"/> irregular heart beat | <input type="checkbox"/> blue or purple skin |
| <input type="checkbox"/> arteriosclerosis | <input type="checkbox"/> pain over heart | <input type="checkbox"/> heart "jumps" | <input type="checkbox"/> rapid heart beat | <input type="checkbox"/> blue or purple nailbeds |

VERTEBRO-BASILAR:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> visual disturbances | <input type="checkbox"/> ringing in ears | <input type="checkbox"/> loss of memory | <input type="checkbox"/> cold hands or feet | <input type="checkbox"/> loss of balance |
| <input type="checkbox"/> irregular muscle action | <input type="checkbox"/> dizziness w/o nausea | <input type="checkbox"/> inability to form words | <input type="checkbox"/> abnormal sensations | <input type="checkbox"/> loss of smell |
| <input type="checkbox"/> muscle weaknesses | <input type="checkbox"/> dizziness w/ nausea | <input type="checkbox"/> fainting spells | <input type="checkbox"/> vertigo | <input type="checkbox"/> loss of taste |

MUSCULOSKELETAL

HEAD

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> frequent headache | <input type="checkbox"/> severe headache | <input type="checkbox"/> head feels heavy | <input type="checkbox"/> lightheadedness |
|--|--|---|--|

NECK

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> neck pain | <input type="checkbox"/> more pain w/movement | <input type="checkbox"/> swelling in neck | <input type="checkbox"/> stiff neck | <input type="checkbox"/> grinding sounds in neck |
| <input type="checkbox"/> pinched nerve in neck | <input type="checkbox"/> neck feels out of place | <input type="checkbox"/> muscle spasms in neck | <input type="checkbox"/> limited movement | <input type="checkbox"/> popping sounds in neck |

SHOULDERS

- | | | | | |
|--|---|---|--|--|
| <input type="checkbox"/> pain in shoulders R/L | <input type="checkbox"/> tension in shoulders | <input type="checkbox"/> pain across upper back | <input type="checkbox"/> shoulder muscle spasm | <input type="checkbox"/> difficulty raising arms |
|--|---|---|--|--|

ARMS & HANDS

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> pain in upper arm | <input type="checkbox"/> pain in hands | <input type="checkbox"/> loss of grip strength | <input type="checkbox"/> swollen finger joint |
| <input type="checkbox"/> pain in forearm | <input type="checkbox"/> pain in fingers | <input type="checkbox"/> fingers go to sleep | <input type="checkbox"/> sore finger joints |

MIDBACK

- | | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> mid back pain | <input type="checkbox"/> mid back spasms | <input type="checkbox"/> shoulder blade pain | <input type="checkbox"/> pain over kidneys | <input type="checkbox"/> pain along course of rib |
|--|--|--|--|---|

LOW BACK

- | | | | | |
|--|---|--|--|---|
| <input type="checkbox"/> low back pain | <input type="checkbox"/> low back feels "out" | <input type="checkbox"/> muscle spasms | <input type="checkbox"/> pinched nerve in back | <input type="checkbox"/> stiff/limited movement |
|--|---|--|--|---|

HIPS, LEGS AND FEET

- | | | | | |
|---------------------------------------|--|------------------------------------|-------------------------------------|------------------------------------|
| <input type="checkbox"/> buttock pain | <input type="checkbox"/> pain down leg | <input type="checkbox"/> knee pain | <input type="checkbox"/> leg cramps | <input type="checkbox"/> foot pain |
|---------------------------------------|--|------------------------------------|-------------------------------------|------------------------------------|