

Health Questionnaire

Please check all of the conditions below that you had and are currently experience

Patient: _____ Date _____ DOB _____

MUSCULAR SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm issues
- Leg issues
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Problems walking
- Spasms
- Broken bones
- Shoulder pain

GENITO-URINARY SYSTEM

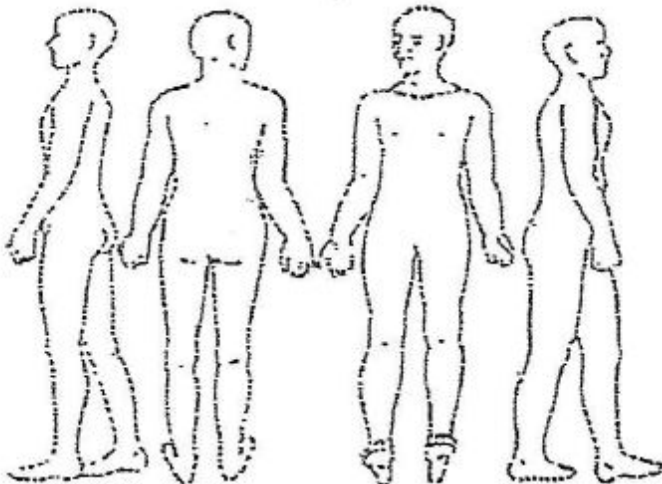
- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine
- FEMALE**
- Vaginal pain
- Breast pain
- Uterine pain
- Ovarian pain
- Yes_NO PREGNANT**

GASTROINTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting blood
- Abdominal Pain
- Diarrhea
- Constipation
- Black stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight problems

CARDIOVASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistant cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart Problems
- Lung problems
- Varicose veins



P ___ Pain
 N ___ Numb
 S ___ Spasm
 T ___ Tender
 H ___ Hypoesthesia

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches/migraine frequency
- Muscle jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

EYES, EARS, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Difficulty breathing
- Sore gums
- Dental problems

- Sore Throat
- Difficult speech
- Sinus
- Allergies
- Jaw pain/clicking/cracking

HABITS

- Smoke (cigarettes/vape/cigars)
- Alcohol daily_ weekly_
- Caffiene daily_ weekly_
- Exercise _times per week
- Drug abuse How often? ___ What kind _____

PATIENT INITIALS _____

