HEALTH QUESTIONNAIKE						
Dear Patient: Please complete this questionnaire. Your	answers will help us	Pa	tient Nam		PATIENT NUME	RED
determine if we can help you. If we do not sincerely belie	ve your condition will		DAT TEA	DIC#	TATIETY INDIVIE)LI(
respond satisfactorily, we will not accept your case. THANK	KYOU.	00	0			000
Please use a No. 2 pencil to fill in your answers. When filling	ng in an Other bubble	20	2000	D D D D C		000
please explain in the space allowed. Fill in bubbles comhere: . Erase changes cleanly. Do not fold this form.	npletely as indicated	00	3 20 0	0000	0000000	000
nere. C. Erase changes cleanly. Do not rold this form.		(4) (1D)	1000	D D D D	DOOOOO	000
A. PATIENT INFORMATION		5 1				
Patient's Home Address		(a) (la)	(TD) (CD) (CD)	and the same of the	0000000	
			20 3 70 0		DODODO	
			30 9 80 0			
			900	D D D D	000000	000
Phone FAX						
Phone FAX	Date Of Birth			Age		
Constant Dualisma Address	Sex: Male	○ Fe	emale			
Employer Business Address	Marital Status:			Resides With		marine 2.22
	○ Single		Clives Alone Spouse Parer			arents
	○ Married		O Chi	laren O	Other	
	○ Widowed		Children			
Phone	DivorcedOther		Children	No Hou	v Many? 133	4 5+
Occupation	Other		O Tes	ONO HOW	vivially: OOC	
Social Security #	Spouse					
	Name	Name				
Referred By	Social Security	#				
B. COMPLAINTS	The second second	-	ALC: NO.		To the second of the second	
Qdifutitightes as as the first of the state	Weghell Agi		hithese neskne	211	Pair Juri Indilling ress	200
		DICTORS				
- PODDSSWS Neck PODSSW	DO R L DO	-	3 W 3	Head	PODSSW PODSSW	® R
	DO R L DO	000	3 W 3	Head Neck	T T T T T T	® R
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PBDSSWS Upper Back PBDSS			3 W 3 3 W 3 3 W 3	Head Neck Upper Back	P	R G G H T
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PBOSSWS Upper Back PBOSSW PBOSSWS Mid Back PBOSSW PBOSSWS Lower Back PBOSSW PBOSSWS Shoulder PBOSSW PBOSSWS Forearm PBOSSW			(3) (W) (3) (3) (W) (3) (3) (W) (3) (3) (W) (3) (3) (W) (3) (3) (W) (3) (3) (W) (3)	Head Neck Upper Back Mid Back Lower Back Shoulder Arm Forearm		R I G H T S S R I G S G G G G G G G G G G G G G G G G G
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POOSSONS Upper Back POOSSON Mid Back POOSSON Mid Back POOSSON Mid Back POOSSON POOSSON Lower Back POOSSON POOSSON Shoulder POOSSON Arm POOSSON Forearm POOSSON Wrist POOSSON Wrist POOSSON Hand POOSSON Ribs POOTSSON BUttock POOTSSON BUTTOCK POOTSSON FOR Arm POOTSSON FOOT POOTSSON FOO	LEFT POR	DO SO	3 W 3 S S W 3	Head Neck Upper Back Mid Back Lower Back Shoulder Arm Forearm Wrist Hand Ribs Buttock Hip Thigh Leg Knee Ankle Foot	PO TS S W	RIGHT RIGHT RIGHT
PODOSSONS Upper Back PODOSSON Mid Back PODOSSON Mid Back PODOSSON PODOSSON Mid Back PODOSSON PODOSSON FOOT PODOSSO	LEFT POST POST POST POST POST POST POST POS	DO SO	(3) (W) (S) (S) (W) (S) (W) (S) (W) (S) (W) (S) (S) (S) (S) (S) (S) (S) (S) (S) (S	Head Neck Upper Back Mid Back Lower Back Shoulder Arm Forearm Wrist Hand Ribs Buttock Hip Thigh Leg Knee Ankle Foot Intermittent	PO TS S W	RIGHT RIGHT RIGHT
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TOUR OSSUMS Upper Back PODOSSUMS Lower Back PODOSSUMS Lower Back PODOSSUMS Forearm PODOSSUMS Forearm PODOSSUMS Hand PODOSSUMS Ribs PODOSSUMS Buttock PODOSSUMS Hip PODOSSUMS Hip PODOSSUMS Thigh PODOSSUMS Thigh PODOSSUMS Forearm PODOSSUMS Buttock PODOSSUMS Hip PODOSSUMS Hip PODOSSUMS Thigh PODOSSUMS Foot PODOSSUMS Foot PODOSSUMS Ankle PODOSSUMS Foot PODOSSUMS Ankle PODOSSUMS Foot	LEPG T PG T	DO SO	(3) (W) (S) (S) (W) (S) (W) (S) (W) (S) (W) (S) (S) (S) (S) (W) (S) (S) (S) (S) (S) (S) (S) (S) (S) (S	Head Neck Upper Back Mid Back Lower Back Shoulder Arm Forearm Wrist Hand Ribs Buttock Hip Thigh Leg Knee Ankle Foot Symptoms (Intermittent Other	PODSSW	RIGHT RIGHT RIGHT
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7. Are You Getting?	Better Worse Same	10. Have You Had Recent To	reatment For This Condition?
		○ Yes ○ No If Yes, Li	st Dates, Treatments, And Doct
	nclude Pain, Is It Aggravated By?		
Coughing	ReachingStanding		
Sneezing	○ Lifting ○ Walking		
 Straining At Stool 			
Neck Movement	Sitting	11. Has This Condition Exis	sted In The Past? Yes
9. If Your Complaints I	nclude Pain, Is It Relieved By?	12. Since Your Symptoms Bo	egan, Have You Noticed A Char
Nothing			Onset Date Duration
Rest	StretchingStanding	 Bowel Function 	
o Ice	Exercise Other	 Bladder Function 	
		Sexual Function	
REVIEW OF SYST	FMS		AT 20mm 10 20 数据 文本的
I. Are You Currently S	uffering From Any Of The	g.Mouth/Throat	
Symptoms Listed B	elow?	Normal	Absence Of Taste
a. General		Sores	Abnormal Taste
○ Normal		Bleeding	Tonsilitis
○ Fatigue	O Chills	 Enlarged Glands 	Other
Weakness	 Weight Change 		
o Fever	O Night Sweats	h. Cardio-Vascular-Pulmor	nary (Heart/Lungs)
Loss Of Sleep	Other	<u>Normal</u>	 Varicosities
		○ Cough	○ Murmur
b. Skin		Wheezing	Chest Pain
Normal	○ Eczema	 Difficulty Breathing 	 Palpitations
○ Rash	 Hair Changes 	 Swollen Extremities 	Other
Redness	 Nail Changes 	○ Blue Extremities	
Itching	Bruise Easily		
Dryness	Other	i. Breasts	
		○ <u>Normal</u>	Dimpling
c. Neurologic		Lumps In Breast(s)	 Discharge
<u>Normal</u>	Convulsions	Redness/Itching	Other
 Headache 	Nervousness	○ Pain	
 Dizziness 	Other Other		
Fainting		j. Gastrointestinal (Stoma	
		<u>Normal</u>	Excess Gas
d. Eyes	Nobe 1 of	 Decreased Appetite 	Vomiting
	Right Left	Increased Appetite	O Diarrhea
Vision Trouble	0 0	Abdominal Pain	 Constipation
Pain	0 0	 Hemorrhoids 	Other Other
Discharge	0 0	1.0.11	
Other	Right	k. Genitourinary	Delet I Manager
	Left	Normal	Painful Menstruation Absorbed Verinal Blanding
		Inability To Hold Urine	
		Delegal Halandian	
e. Ears	Nobe Loss	O Painful Urination	O Impotence
<u>Normal</u>	Right Left	 Frequent Urination 	Sterility
Normal Hearing Trouble	0 0	Frequent UrinationBedwetting	SterilityProstate Problems
NormalHearing TroubleRinging	0 0	 Frequent Urination 	SterilityProstate Problems
 Normal Hearing Trouble Ringing Pain 	0 0 0	Frequent UrinationBedwettingIrregular Menstruation	SterilityProstate ProblemsOther
○ <u>Normal</u> Hearing Trouble Ringing Pain Discharge		Frequent UrinationBedwettingIrregular Menstruation I. Endocrine (Metabolism)	SterilityProstate ProblemsOther
○ <u>Normal</u> Hearing Trouble Ringing Pain	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	 Frequent Urination Bedwetting Irregular Menstruation I. Endocrine (Metabolism) Normal 	Sterility Prostate Problems Other Goiter
○ <u>Normal</u> Hearing Trouble Ringing Pain Discharge		Frequent Urination Bedwetting Irregular Menstruation I. Endocrine (Metabolism) Normal Heat/Cold Intolerance	Sterility Prostate Problems Other Goiter Tremor
Normal Hearing Trouble Ringing Pain Discharge Other	Right	 Frequent Urination Bedwetting Irregular Menstruation I. Endocrine (Metabolism) Normal 	Sterility Prostate Problems Other Goiter
 Normal Hearing Trouble Ringing Pain Discharge Other 	Right Left	Frequent Urination Bedwetting Irregular Menstruation I. Endocrine (Metabolism) Normal Heat/Cold Intolerance	Sterility Prostate Problems Other Goiter Tremor
Normal Hearing Trouble Ringing Pain Discharge Other	Right Left Infections Absence Of Smell	Frequent Urination Bedwetting Irregular Menstruation I. Endocrine (Metabolism) Normal Heat/Cold Intolerance Sugar In Urine	Sterility Prostate Problems Other Goiter Tremor
Normal Hearing Trouble Ringing Pain Discharge Other f. Nose Normal	Right Left Infections Absence Of Smell Other	Frequent Urination Bedwetting Irregular Menstruation I. Endocrine (Metabolism) Normal Heat/Cold Intolerance Sugar In Urine mPsychologic	Sterility Prostate Problems Other Goiter Tremor Other

A	C. REVIEW OF SYSTEMS (CONTINUED)	2. If you now have or you have had one of the following
	2. What Hobbies Do You Participate In?	illnesses, please fill in <u>EITHER</u> bubble NH or bubble HH.
	List Hobbies: Occasionally Frequently Constantly	No Previous Conditions/Illnesses
	1.	be, she be she
	2.	Mon Have Had
	3.	
V	DeckelDen	Arthritis Sexually Transmitted Disease
	3. What Are Your Habits? Packs/Day Never <1 1-2 2-3 3-4 5+	⊕ Asthma ⊕ Ulcer
U	Silloking	⊞ Sinus Trouble ⊞ Cancer
NA	Drinks/Day Never <1 1-2 2-3 3-4 5+	⊞ Hay Fever ⊞ Polio
Δ	Alcorioi 0 0 0 0 0	Allergies
R	Cups-Glasses/Day	⊕ Tuberculosis ⊕ Serious Injury
K	Caffeinated Drinks Never 5 1-2 2-3 3-4 5+	⊞ Diabetes
S	Days/Week	Epilepsy
_	Exercise Never <1 1-2 3-4 5-6 7	Thyroid Trouble
H	Name Van	⊕ High Blood Pressure ⊕ ← Multiple Sclerosis
E	Drug/Substance Abuse Never Yes, Discuss With Doctor	⊕ Low Blood Pressure ⊕ Scoliosis
R		■ Heart Trouble ■ Mental/Emotional Difficulty
E	D. MEDICAL HISTORY	
1	1. Health Care	■ HIV/ARC ■ Kidney Trouble
	a. Have You Been To A Chiropractor Yes No	■ AIDS ■ Other
	b. Do You Have A Family Physician	Other
	Date Of Last Physical Exam	
	Physician's Name & Address	Father CDBBSBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBB
		11/2/18/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/
Ň		1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
0	c. Have You Been Hospitalized In The Past	Father Common Co
	Five Years	
M	Date & Reason For Hospitalization	
A	But a reason of respiratization	Father COBBSBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBB
R		Mother COBBSBBBBBBBBBBBBB
K	d. Have You Had Surgery In The Past	Bro 1 COBBS WBBDDAPOSB O
S	Five Years Yes No	Bro 2 COBBSBBBBBBBBBBBBB
	Date & Reason For Surgery	Bro 3 COBOSODO BOJADOS B
H	Date & Reason For Surgery	Sis 1 COBOSODO DO DO SO
Ε	e. Have You Had A Serious Accident In The Past	
R	Five Years Yes No	
4	Auto Work Home Other	
	List Date & Describe Injury	
	List Date & Describe Injury	Child 2 COBBS BBB BB DADOS B O
	f. Do You Have Any Drug Allergies Yes No	Child 3 COBBSBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBBB
	f. Do You Have Any Drug Allergies	F OCCUPATIONAL INFORMATION -
	List Drugs	E. OCCUPATIONAL INFORMATION - ACTIVITIES OF DAILY LIVING
¥		1. Job Type
N		100
0	Anti-inflammatory (Aspirin, Motrin, etc.)	Full Time Temporary
d.	Muscle Relaxants Pain Medication/Analgesic	Other
M	Tranquilizers Antibiotics	A 14/ 1 14/ 1
A	○ Blood Pressure Pills ○ Other	2. Work Week Hours Per Day 1 2 3 4 5 6 7 8 9 10 11 12
ベ	Birth Control Pills	Days Per Week 1234567
0	For What Condition/s Are You Taking Medication?	
0		Other
4	I WONEY ONLY	0 B V B 10 11 17 17 17
_	h. WOMEN ONLY:	3. Do Your Present Complaints Affect The Number
2	To Your Knowledge Are You Pregnant Yes No No Have Your Past Pregnancies Been Normal Yes Are You Seeing An OB-GYN Regularly	Of Hours You Work Per Day Yes No
=	Have Your Past Pregnancies Been Normal	
		4. Length Of Time At Present Occupation
	Date Of Last Exam	10 20 30 40 50
	Physician's Name & Address	Years 9 9 9 9 9
		99999999
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E. OCCUPATIONAL INFORMATION - ACTIVITIES OF DAILY LIVING (CONTINUED)	5. HMO, PPO Plan Coverage
5 Joh Involves	Policy #
a. Lifting So	6. Are You Covered By Medicare Yes Medicare #
b. Additional Job Requirements Bending Twisting Carrying	7. Authorization To Release Records To Patient's Insurance Carrier
Stooping Turning Walking Other	Patient or Guardian's Signature
6. What Is Your Primary Work Position \ Location? a. Position: b. Location:	G. PAYMENT
Seated Desk Counter Standing Workbench Other Other	IF YOU HAVE MADE PRIOR FINANCIAL ARRANGEMENTS WITH OUR OFFICE THE FOLLOWING PARAGRAPH WILL NOT APPLY TO YOU.
c. If Seated, What Type Of Chair Do You Use? Executive Steno Bench Stool Other	I understand and agree that health and accident policies are are arrangement between an insurance carrier and myself. Furthermore, understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Office will be
7. Do You Wear Shoes Or Boots With High Heels? Never Seldom Occasionally Frequently	credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees fo professional services rendered me will be immediately due and
8. Are You Right Or Left Handed? Right Cleft	payable.
9. Do Work Activities Aggravate Your Present Complaints? Yes No	I WILL BE PAYING TODAY BY: (If paying by credit card please confirm which cards are accepted by our office.) Cash Check Visa MasterCard DiscoverCard American
10. Which Of The Following Best Describes Your Stress Level?	Other Express
None Minimal Moderate Great	Account # Expiration Date
11. How Do You Rate Your Physical Activity At Work? Seated more than 50% of workday Light Manual Labor Moderate Manual Labor Heavy Manual Labor	Patient's Signature Date
presentativizativ 🕷 vom additivizat od engravi	Guardian or Spouse's Signature Date
F. INSURANCE INFORMATION 1. Is Your Condition Due To:	
An Automobile Accident	Doctor's Signature Date
2. Do You Have Health Insurance Yes No Company Policy #	Is There Anything Else You Would Like Us To Know? Yes No
3. Is Your Spouse Employed Yes No Business Address	
4. Is Your Spouse The Primary Insured Yes No Company Policy #	