 HEALTH QUESTIONNAIRE

PLEASE CHECK EACH OF THE CONDITIONS BELOW THAT YOU ARE **CURRENTLY** EXPERIENCING

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MUSCULOSKELETAL NEUROLOGICAL OTOLARYNGOLOGICAL**

❑ Neck pain ❑ Numbness ❑ Eye strain

❑ Shoulder pain ❑ Tingling ❑ Eye inflammation

❑ Upper back pain ❑ Paralysis ❑ Vision problems

❑ Mid back pain ❑ Loss of feeling ❑ Ear pain

❑ Lower back pain ❑ Dizziness ❑ Tinnitis (ringing in ears)

❑ Arm problems ❑ Fainting ❑ Nose stuffiness

❑ Leg problems ❑ Headaches ❑ Mouth soreness

❑ Walking problems ❑ Muscle jerking ❑ Dental problems

❑ Muscle soreness ❑ Convulsions ❑ Sore throat

❑ Muscle spasms ❑ Forgetfulness ❑ Hoarseness

❑ Muscle weakness ❑ Confusion ❑ Speech difficulty

❑ Joint stiffness ❑ Depression ❑ Sinus problems

❑ Joint swelling or pain ❑ Insomnia ❑ Allergy problems

❑ Broken bones ❑ Anxiety ❑ Jaw pain

**GASTRO-INTESTINAL CARDIO-VASCULAR URINARY-GENITAL**

❑ Poor appetite ❑ Chest pain ❑ Bladder trouble

❑ Excessive hunger ❑ Difficulty breathing ❑ Excessive urination

❑ Difficulty chewing ❑ Persistent cough ❑ Scanty urination

❑ Difficulty swallowing ❑ Rapid heartbeat ❑ Painful urination

❑ Excessive thirst ❑ High blood pressure ❑ Discolored urine

❑ Nausea/Vomiting ❑ Heart problems ❑ Painful menstrual cramping

❑ Abdominal pain ❑ Lung problems ❑ Currently pregnant

❑ Constipation

❑ Diarrhea **RATE PAIN ON A SCALE OF 1-10 (1 = LEAST AND 10 = MOST) & INDICATE SIDE**

❑ Black or bloody stool ❑ HEAD \_\_\_\_\_\_\_\_\_\_ ❑ NECK \_\_\_\_\_\_\_\_\_\_\_

❑ Hemorrhoids ❑ SHOULDER \_\_\_\_\_\_\_\_\_\_ ❑ UPPER BACK \_\_\_\_\_\_\_\_\_\_

❑ Liver trouble ❑ MID BACK \_\_\_\_\_\_\_\_\_\_ ❑ LOW BACK \_\_\_\_\_\_\_\_\_\_

❑ Gall bladder problems ❑ ELBOW \_\_\_\_\_\_\_\_\_\_ ❑ WRISTS \_\_\_\_\_\_\_\_\_\_\_

❑ Weight trouble ❑ KNEES \_\_\_\_\_\_\_\_\_\_ ❑ ANKLES \_\_\_\_\_\_\_\_\_\_\_

❑ HANDS \_\_\_\_\_\_\_\_\_\_ ❑ FEET \_\_\_\_\_\_\_\_\_\_\_`

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