

# HEALTH QUESTIONNAIRE

**Dear Patient:** Please complete this questionnaire. Your answers will help us determine if we can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. **THANK YOU.**

Please use a **No. 2 pencil** to fill in your answers. When filling in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here: . **Erase** changes cleanly. Do **not fold** this form.

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

MO	DAY	YEAR	DR#	PATIENT NUMBER									
① 7	①	① 0	① ① ① ① ① ① ① ① ① ① ① ①	① ① ① ① ① ① ① ① ① ① ① ①									
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		90 9											

Date Of Birth \_\_\_\_\_  
Social Security # \_\_\_\_\_

Patient's Home Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone \_\_\_\_\_ FAX \_\_\_\_\_

Employer Business Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone \_\_\_\_\_

Occupation \_\_\_\_\_

Referred By \_\_\_\_\_

Spouse Name \_\_\_\_\_  
Social Security # \_\_\_\_\_

**Sex:**  
 Male  
 Female

**Marital Status:**  
 Single  
 Married  
 Widowed  
 Divorced  
 Other

**Patient Resides With:**  
 Lives Alone  Spouse  Parents  
 Children  Other  
**Children:**  0  1  2  3  4  5+

## A. MAJOR COMPLAINTS

1. What are your major complaints?

<input type="radio"/> None	<b>Pain</b>	<b>Numbness</b>	<b>Tingling</b>
Head	① H	① H	① H
Neck	① N	① N	① N
Upper Back	① U	① U	① U
Mid Back	① M	① M	① M
Lower Back	① L	① L	① L
	<b>R</b>	<b>L</b>	<b>R</b>
	<b>L</b>	<b>R</b>	<b>L</b>
Shoulder	① S	① S	① S
Arm	① A	① A	① A
Forearm	① F	① F	① F
Hand	① H	① H	① H
Buttock	① B	① B	① B
Hip	① H	① H	① H
Thigh	① T	① T	① T
Leg	① L	① L	① L
Foot	① F	① F	① F

2. Currently your pain is aggravated by

- Coughing
- Sneezing
- Straining At Stool
- Neck Movement
- Reaching
- Other
- Lifting
- Bending
- Sitting
- Standing
- Walking

3. Since your symptoms began, have you noticed a change in

- Bowel Function
- Ability To Maintain An Erection
- Bladder Function

## B. REVIEW OF SYSTEMS

Are you presently suffering (or within the past six months suffered) from any of the following?

- 1. a. GENERAL**
- Normal
  - Fatigue
  - Weakness
  - Fever
  - Chills
  - Weight Change
  - Night Sweats
  - Other
- b. SKIN**
- Normal
  - Rash
  - Redness
  - Itching
  - Eczema
  - Hair Changes
  - Nail Changes
  - Other
- c. NEUROLOGIC**
- Normal
  - Headache
  - Dizziness
  - Fainting
  - Convulsions
  - Other
- d. EYES**
- |                              |              |             |
|------------------------------|--------------|-------------|
| <input type="radio"/> Normal | <b>Right</b> | <b>Left</b> |
| Vision Trouble               | ○            | ○           |
| Pain                         | ○            | ○           |
| Discharge                    | ○            | ○           |
| Other                        | ○            | ○           |
- e. EARS**
- |                              |              |             |
|------------------------------|--------------|-------------|
| <input type="radio"/> Normal | <b>Right</b> | <b>Left</b> |
| Hearing Trouble              | ○            | ○           |
| Ringing                      | ○            | ○           |
| Pain                         | ○            | ○           |
| Discharge                    | ○            | ○           |
| Other                        | ○            | ○           |
- f. NOSE**
- Normal
  - Pain
  - Bleeding
  - Absence Of Smell
  - Other
- g. MOUTH/THROAT**
- Normal
  - Sores
  - Bleeding
  - Absence Of Taste
  - Abnormal Taste
  - Other

- h. HEART/LUNGS**
- Normal
  - Cough
  - Wheezing
  - Difficulty Breathing
  - Swollen Extremities
  - Blue Extremities
  - Murmur
  - Chest Pain
  - Palpitations
  - Other
- i. BREASTS**
- Normal
  - Lumps In Breast(s)
  - Redness/Itching
  - Pain
  - Dimpling
  - Discharge
  - Other
- j. STOMACH/INTESTINES**
- Normal
  - Decreased Appetite
  - Increased Appetite
  - Abdominal Pain
  - Vomiting
  - Diarrhea
  - Constipation
  - Other
- k. REPRODUCTIVE/URINATION**
- Normal
  - Inability To Hold Urine
  - Painful Urination
  - Frequent Urination
  - Irregular Menstruation
  - Painful Menstruation
  - Abnormal Vaginal Bleeding
  - Impotence
  - Sterility
  - Other
- l. GLANDULAR**
- Normal
  - Heat/Cold Intolerance
  - Sugar In Urine
  - Goiter
  - Tremor
  - Other
- m. MENTAL**
- Normal
  - Anxiety
  - Depression
  - Memory Loss or Impairment
  - Phobias
  - Mood Swings
  - Other