

# Comprehensive Health Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: ☐ Female ☐ Male  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

In order for us to serve you better, it is important for us to understand your complete health history as well as have a thorough knowledge of all of your health-related complaints. All of your information will be kept strictly confidential and will become part of your patient record. If you need any assistance in completing this questionnaire, please don't hesitate to ask. It is our please to serve you. **Please check all that apply.**

## REVIEW OF BODY SYSTEMS

### CARDIOVASCULAR/ HEART AND BLOOD VESSELS

<u>Past</u>	<u>Present</u>		<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	Blocked Arteries	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Rate
<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker/Defibrillator
<input type="checkbox"/>	<input type="checkbox"/>	Cold Hands and/or Feet	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation
<input type="checkbox"/>	<input type="checkbox"/>	Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	Slow Heart Rate
<input type="checkbox"/>	<input type="checkbox"/>	Fast Heart Rate	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Ankles/Legs
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur/Valve Problems	<input type="checkbox"/>	<input type="checkbox"/>	Other:

### PULMONARY/LUNGS

<u>Past</u>	<u>Present</u>		<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Persistent Cough
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Chest Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Smoker's Cough
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pulmonary Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	COPD	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing			

### NERVOUS SYSTEM

<u>Past</u>	<u>Present</u>		<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision/Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Neuropathy
<input type="checkbox"/>	<input type="checkbox"/>	Cold Hands and/or Feet	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Tingling in Arms/Hands
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Tingling in Legs/Hands
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Other Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Balance	<input type="checkbox"/>	<input type="checkbox"/>	Referred/Radiating Pain
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Grip Strength	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in Ears
<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Tension or Stress Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Muscle Atrophy/Wasting	<input type="checkbox"/>	<input type="checkbox"/>	Other:

## DIGESTION

<u>Past</u>	<u>Present</u>		<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux (GERD)	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain or Clicking/TMJ
<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease/Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Poor Digestion
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Rectal Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Reduced Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Hiatal Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Other:

## ENDOCRINE/GLANDS

<u>Past</u>	<u>Present</u>		<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Addison's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Low Sex Drive
<input type="checkbox"/>	<input type="checkbox"/>	Cushing's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Low Thyroid
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Over-Active Thyroid
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis
<input type="checkbox"/>	<input type="checkbox"/>	Heavy Menstrual Flow	<input type="checkbox"/>	<input type="checkbox"/>	Pituitary Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>	Slow Metabolism
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>	Other:

## URINARY/REPRODUCTIVE

<u>Past</u>	<u>Present</u>		<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>	Infertility
<input type="checkbox"/>	<input type="checkbox"/>	Bladder Leakage	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infections/ Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	Cystic Breasts	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian Cysts
<input type="checkbox"/>	<input type="checkbox"/>	Enlarged Prostate/Prostatitis	<input type="checkbox"/>	<input type="checkbox"/>	Uterine Fibroids
<input type="checkbox"/>	<input type="checkbox"/>	Erectile Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids			

## FEMALES ONLY

<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Are You Pregnant Now?	<input type="checkbox"/>	<input type="checkbox"/>	Partial or Complete Hysterectomy
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Menstrual Flow	<input type="checkbox"/>	<input type="checkbox"/>	Peri-Menopause
<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>	PMS
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstrual Cycle	<input type="checkbox"/>	<input type="checkbox"/>	Taking Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/>	Menopause	<input type="checkbox"/>	<input type="checkbox"/>	Tubal Ligation
<input type="checkbox"/>	<input type="checkbox"/>	Miscarriage(s) – How many? _____	<input type="checkbox"/>	<input type="checkbox"/>	Other:
Last Menstrual Cycle:					

## MUSCLES, BONES & JOINTS

<u>Past</u>	<u>Present</u>		<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis - Location: _____	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Spasms
<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Carpal Tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	Degenerative Joint Disease	<input type="checkbox"/>	<input type="checkbox"/>	Painful Joints
<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Foot Problems/Fallen Arches	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis (Spinal Curvature)
<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Spinal Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Herniated Disc(s)	<input type="checkbox"/>	<input type="checkbox"/>	Swollen/Painful Joints
<input type="checkbox"/>	<input type="checkbox"/>	Hip Pain – Which side? _____	<input type="checkbox"/>	<input type="checkbox"/>	Weak Muscles/Atrophy
<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Other:

## SKIN

<u>Past</u>	<u>Present</u>		<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Acne	<input type="checkbox"/>	<input type="checkbox"/>	Itching
<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Oily Skin
<input type="checkbox"/>	<input type="checkbox"/>	Dry Skin	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive Skin
<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Suspicious Moles/Marks
<input type="checkbox"/>	<input type="checkbox"/>	Hives Frequently	<input type="checkbox"/>	<input type="checkbox"/>	Other:

## EYES, EARS, NOSE, THROAT

<u>Past</u>	<u>Present</u>		<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	Nasal Obstruction/Sinus Blockage
<input type="checkbox"/>	<input type="checkbox"/>	Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Poor Vision
<input type="checkbox"/>	<input type="checkbox"/>	Earches	<input type="checkbox"/>	<input type="checkbox"/>	Ringling of Ears
<input type="checkbox"/>	<input type="checkbox"/>	Enlarged Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds/Flu	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Other:

## PSYCHOLOGICAL/MENTAL/EMOTIONAL

<u>Past</u>	<u>Present</u>		<u>Past</u>	<u>Present</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Addiction Disorder - Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Problems
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Memory
<input type="checkbox"/>	<input type="checkbox"/>	Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Panic Attacks
<input type="checkbox"/>	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	<input type="checkbox"/>	Psychological Counseling/Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Seizure/Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Other:

## LIFESTYLE/HABITS

How many hours of television do you typically watch per day? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5

How many hours of computer time do you spend per day (work and home)? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5

How many hours per day do you spend in a car (or other vehicle)? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ >5

How often do you exercise? ☐ Daily ☐ 3-5x/wk ☐ 1-2x/wk ☐ Rarely ☐ I don't exercise

How long do your exercise sessions last? ☐ 20-30 min ☐ 30 min-1hr ☐ > 1hr

What type of exercise do you do? (check all that apply)

☐ Aerobics ☐ Climbing ☐ Pilates ☐ Resistance Bands ☐ Rowing ☐ Running Treadmill

☐ Stretching/Flexibility ☐ Swimming ☐ Walking ☐ Weight Lifting ☐ Yoga

☐ Other: \_\_\_\_\_

Do you currently smoke cigarettes? ☐ Yes ☐ No Packs per day: \_\_\_\_\_ How many years: \_\_\_\_\_

Did you smoke cigarettes in the past? ☐ Yes ☐ No Packs per day: \_\_\_\_\_ How many years: \_\_\_\_\_

Do you use other tobacco products? ☐ No ☐ Cigars ☐ Chewing Tobacco

How many servings of alcohol do you consume each day? ☐ 0-1 ☐ 1-2 ☐ 3-5 ☐ >5

How many servings of coffee do you drink each day? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5 ☐ Decaf ☐ Regular

How many servings of soda do you drink each day? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ >5 ☐ Diet ☐ Regular

## FAMILY HISTORY

	<u>Father</u>	<u>Mother</u>	<u>Brother</u>	<u>Sister</u>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back or Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity/Weight Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## CANCER HISTORY

Have you ever been diagnosed with cancer? ☐ Yes ☐ No

<u>Past</u>	<u>Present</u>	<u>Yr Diagnosed</u>	<u>Past</u>	<u>Present</u>	<u>Yr Diagnosed</u>
<input type="checkbox"/>	<input type="checkbox"/>	Blood/Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Lung
<input type="checkbox"/>	<input type="checkbox"/>	Bone	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian/Uterine
<input type="checkbox"/>	<input type="checkbox"/>	Bowel/Colon	<input type="checkbox"/>	<input type="checkbox"/>	Pancreas
<input type="checkbox"/>	<input type="checkbox"/>	Brain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate
<input type="checkbox"/>	<input type="checkbox"/>	Breast	<input type="checkbox"/>	<input type="checkbox"/>	Skin
<input type="checkbox"/>	<input type="checkbox"/>	Head/Neck	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid
<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

What type of treatment did you receive? \_\_\_\_\_

INFECTIOUS DISEASES - Please check all conditions you have or once had.

Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease (STD)
<input type="checkbox"/>	<input type="checkbox"/>	Malaria	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>	Other:

CONDITIONS - Please check all conditions you have or once had.

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mental Disorder	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Goiter	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mumps	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Whiplash
<input type="checkbox"/> Cancer	<input type="checkbox"/> Influenza	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Measles	<input type="checkbox"/> Polio	

SURGERIES - Please check all surgeries you have had.

<input type="checkbox"/> Appendix Removed	<input type="checkbox"/> Knee
<input type="checkbox"/> Breast Enlargement	<input type="checkbox"/> Pacemaker/Defibrillator
<input type="checkbox"/> Breast Reduction	<input type="checkbox"/> Rectal/Hemorrhoid
<input type="checkbox"/> Mastectomy	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Complete/Partial Hysterectomy	<input type="checkbox"/> Stomach/Intestines
<input type="checkbox"/> Gallbladder Removed	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Heart – Type of Surgery: _____	<input type="checkbox"/> Other:
<input type="checkbox"/> Joint Replacement - List Joint: _____	

AUTO INJURIES – Please list all significant motor vehicle collisions you have been involved in.

(1) Date of Collision: _____	Injuries Received: _____
(2) Date of Collision: _____	Injuries Received: _____
(3) Date of Collision: _____	Injuries Received: _____

WORK INJURIES – Please list all work injuries you have experienced.

(1) Date of Injury: _____	Injuries Received: _____
(2) Date of Injury: _____	Injuries Received: _____
(3) Date of Injury: _____	Injuries Received: _____

SPORTS INJURIES – Please list all sports injuries (such as back, knee, neck, shoulder, spine, etc.)

(1) Date of Injury: _____	Type of Injury: _____
(2) Date of Injury: _____	Type of Injury: _____
(3) Date of Injury: _____	Type of Injury: _____

## MEDICATIONS

I currently take **prescription medication(s)** for the following conditions:

- |  |  |  |                                   |
|--|--|--|-----------------------------------|
| <input type="checkbox"/> Acid Reflux   | <input type="checkbox"/> Blood Thinner   | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid  |
| <input type="checkbox"/> Allergies     | <input type="checkbox"/> Depression      | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Anxiety       | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Kidneys             | <input type="checkbox"/> _____    |
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Female Problems | <input type="checkbox"/> Migraines           | <input type="checkbox"/> _____    |
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Fibromyalgia    | <input type="checkbox"/> Prostate            | <input type="checkbox"/> _____    |
| <input type="checkbox"/> Birth Control | <input type="checkbox"/> Heart           | <input type="checkbox"/> Sinus               | <input type="checkbox"/> _____    |

I currently take **non-prescription medication(s)** or **herbal remedies** for the following conditions:

- |  |   |  |                                    |
|--|---|--|------------------------------------|
| <input type="checkbox"/> Acid Reflux     | <input type="checkbox"/> Blood Thinner          | <input type="checkbox"/> Fibromyalgia        | <input type="checkbox"/> Sinus     |
| <input type="checkbox"/> Allergies       | <input type="checkbox"/> Cholesterol            | <input type="checkbox"/> Heart               | <input type="checkbox"/> Sleep Aid |
| <input type="checkbox"/> Anxiety         | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid   |
| <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Depression             | <input type="checkbox"/> Kidneys             | <input type="checkbox"/> _____     |
| <input type="checkbox"/> Aspirin Therapy | <input type="checkbox"/> Digestion              | <input type="checkbox"/> Migraine            | <input type="checkbox"/> _____     |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Female Issues/Problems | <input type="checkbox"/> Prostate            | <input type="checkbox"/> _____     |

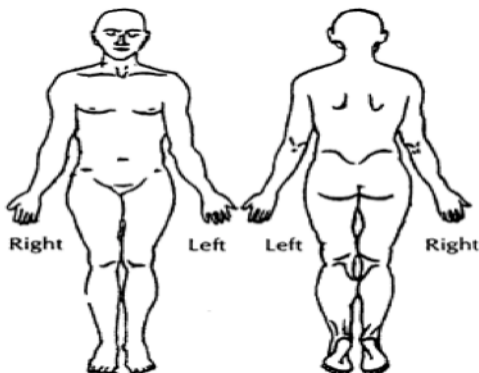
## VITAMINS

Do you take a multivitamin?    ☐ Yes    ☐ No

List any other nutritional supplements you currently take on a regular basis:

- |   |                                    |                                |
|---|------------------------------------|--------------------------------|
| <input type="checkbox"/> B Vitamins       | <input type="checkbox"/> Minerals  | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Calcium          | <input type="checkbox"/> Vitamin C | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Fiber            | <input type="checkbox"/> Vitamin D | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Fish or Flax Oil | <input type="checkbox"/> Vitamin E | <input type="checkbox"/> _____ |

Please mark areas where you feel pain, numbness, tingling or weakness on the diagram:



P = Pain    N= Numbness    T= Tingling    W= Weakness

For Office Use Only:

When was the last time you felt really great? ☐ <1 mo ☐ 1-6 mo ☐ 6 mo-1 yr ☐ 1-2 yr ☐ 2-5 yr ☐ 5+ yr

## Activities of Daily Living

To properly assess your condition, we must understand how much your health problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

<b>1. Pain Intensity</b>	<b>0</b> _____	<b>1</b> _____	<b>2</b> _____	<b>3</b> _____	<b>4</b> _____
	No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
<b>2. Sleeping</b>	<b>0</b> _____	<b>1</b> _____	<b>2</b> _____	<b>3</b> _____	<b>4</b> _____
	Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep
<b>3. Personal Care (washing, dressing, etc)</b>	<b>0</b> _____	<b>1</b> _____	<b>2</b> _____	<b>3</b> _____	<b>4</b> _____
	No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance
<b>4. Travel (driving, etc.)</b>	<b>0</b> _____	<b>1</b> _____	<b>2</b> _____	<b>3</b> _____	<b>4</b> _____
	No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips
<b>5. Work</b>	<b>0</b> _____	<b>1</b> _____	<b>2</b> _____	<b>3</b> _____	<b>4</b> _____
	Can do usual work; plus unlimited extra	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work
<b>6. Recreation</b>	<b>0</b> _____	<b>1</b> _____	<b>2</b> _____	<b>3</b> _____	<b>4</b> _____
	Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities
<b>7. Frequency of pain</b>	<b>0</b> _____	<b>1</b> _____	<b>2</b> _____	<b>3</b> _____	<b>4</b> _____
	No pain	Occasional pain 25% of day	Intermittent pain 50% of day	Frequent pain 75% of day	Constant pain 100% of day
<b>8. Lifting</b>	<b>0</b> _____	<b>1</b> _____	<b>2</b> _____	<b>3</b> _____	<b>4</b> _____
	No pain with heavy weight	Incr'd pain with heavy weight	Incr'd pain with moderate weight	Incr'd pain with light weight	Incr'd pain with any weight
<b>9. Walking</b>	<b>0</b> _____	<b>1</b> _____	<b>2</b> _____	<b>3</b> _____	<b>4</b> _____
	No pain any distance	Incr'd pain after 1 mile	Incr'd pain after ½ mile	Incr'd pain after ¼ mile	Incr'd pain with all walking
<b>10. Standing</b>	<b>0</b> _____	<b>1</b> _____	<b>2</b> _____	<b>3</b> _____	<b>4</b> _____
	No pain after several hours	Incr'd pain after several hours	Incr'd pain after 1 hour	Incr'd pain after ½ hour	Incr'd pain with any standing

Patient's Signature \_\_\_\_\_ Today's Date: \_\_\_\_\_