COMPREHENSIVE HEALTH EVALUATION

We are asking you to answer to following questions as accurately as possible. Your answers will provide us with important information that can help in determining those factors which may be effecting your health.

Name _____ Date _____

What is your present major complaint _____

_____

1. Is your condition caused by: ☐ Work injury ☐ Auto accident ☐ Illness
   ☐ Fall ☐ Other (specify) _____
2. Date of above injury/accident/illness or when your first noticed it: _____
3. Duration and frequency of your pain? _____
4. Does any position relieve your pain? (explain) _____
5. What makes your condition worse? _____
6. Is it ☐ Better in the Morning? ☐ Worse in the Morning? ☐ Better in the Evening? ☐ Worse in the Evening?
7. Does it interfere with your: ☐ Work? ☐ Standing ☐ Walking ☐ Sitting
   ☐ Bending ☐ Stooping ☐ Lifting ☐ Pulling ☐ Pushing ☐ Reaching ☐ Gripping
   ☐ Climbing ☐ Kneeling ☐ Balance ☐ Other _____
8. When bending forward is the pain in your ☐ Neck ☐ Mid back ☐ Low back
9. When bending backwards is the pain in your ☐ Neck ☐ Mid back ☐ Low back
10. When bending sideways (right) is the pain in your ☐ Neck ☐ Mid back ☐ Low back
11. When bending sideways (left) is the pain in your ☐ Neck ☐ Mid back ☐ Low back
12. When twisting sideways (right) is the pain in your ☐ Neck ☐ Mid back ☐ Low back
13. When twisting sideways (left) is the pain in your ☐ Neck ☐ Mid back ☐ Low back
14. List any other movements or positions which cause you pain _____
    _____
15. Have you had previous treatment for this condition? ☐ Yes ☐ No
    If yes, when? _____
16. Who treated you? _____
16. List and give dates of previous accidents or illnesses
    _____
    _____
    _____
17. List and give dates of major illnesses, operations or hospitalizations _____
    _____
    _____
18. Do you feel your present condition is
    ☐ Temporary ☐ Permanent ☐ Don't know

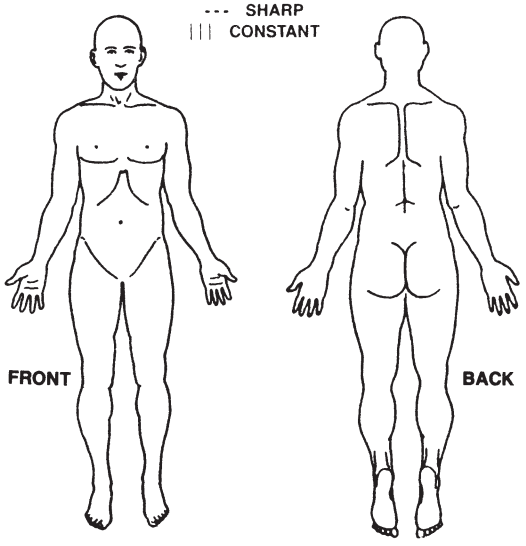
RATE THE SEVERITY OF YOUR PAIN BY CHECKING ONE BOX ON THE FOLLOWING SCALE

1 = LEAST PAIN
10 = EXTREME PAIN

EXTREME
10
9
8
7
6
5
4
3
2
1
0
NO PAIN

MARK AREAS OF PAIN ON THE FIGURES BELOW USING THESE CODES

+ + + BURNING
000 STABBING
--- SHARP
||| CONSTANT



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PATIENT SYMPTOM SURVEY

Patient Name: _____ Date: _____

PLEASE CHECK YOUR PAST & PRESENT SYMPTOMS SO WE CAN BETTER EVALUATE YOUR PROBLEM

GENERAL
PAST NOW
- ☐ ☐ rheumatoid arthritis
- ☐ ☐ osteoarthritis
- ☐ ☐ gout
- ☐ ☐ swollen glands
- ☐ ☐ hot or cold intolerance
- ☐ ☐ weight loss
- ☐ ☐ weight gain
- ☐ ☐ fever or chills
- ☐ ☐ chills
- ☐ ☐ allergies
- ☐ ☐ nervousness
- ☐ ☐ irritable
- ☐ ☐ generally feel rundown
- ☐ ☐ tuberculosis
- ☐ ☐ hepatitis
- ☐ ☐ rhuematic fever
- ☐ ☐ high or low blood pressure
- ☐ ☐ venereal disease
- ☐ ☐ HIV

NERVOUS SYSTEM
- ☐ ☐ dizziness
- ☐ ☐ blurred vision
- ☐ ☐ fainting
- ☐ ☐ paralysis
- ☐ ☐ tremors
- ☐ ☐ numbness/tingling
- ☐ ☐ convulsions
- ☐ ☐ imbalance
- ☐ ☐ memory loss
- ☐ ☐ muscle weakness

URINARY
- ☐ ☐ painful urination
- ☐ ☐ frequent urination
- ☐ ☐ hard to urinate
- ☐ ☐ incontinence
- ☐ ☐ bed wetting
- ☐ ☐ discolored urine
- ☐ ☐ frequent infections
- ☐ ☐ prostate problems
- ☐ ☐ unusual discharge

GASTROINTESTINAL
- ☐ ☐ change in appetite
- ☐ ☐ thirst
- ☐ ☐ nausea
- ☐ ☐ vomiting
- ☐ ☐ diarrhea
- ☐ ☐ constipation
- ☐ ☐ gas
- ☐ ☐ hemorrhoids
- ☐ ☐ gall bladder
- ☐ ☐ belching
- ☐ ☐ heartburn
- ☐ ☐ abdominal pain
- ☐ ☐ bloody/black stools
- ☐ ☐ indigestion
- ☐ ☐ liver trouble

CHEST
- ☐ ☐ chest pain
- ☐ ☐ shortness of breath
- ☐ ☐ pain around ribs

EMOTIONAL
PAST NOW
- ☐ ☐ anxiety or worry
- ☐ ☐ frequent crying
- ☐ ☐ anger
- ☐ ☐ tension
- ☐ ☐ mood swings
- ☐ ☐ fear
- ☐ ☐ restlessness
- ☐ ☐ confusion
- ☐ ☐ depression
- ☐ ☐ suicidal

REPRODUCTIVE SYSTEM
- ☐ ☐ painful intercourse
- ☐ ☐ prostate problems
- ☐ ☐ sexual problems
- ☐ ☐ loss of sex drive
- ☐ ☐ genital infections

Birth Control Method _____

WOMEN ONLY
- ☐ ☐ cramps
- ☐ ☐ PMS
- ☐ ☐ irregular periods

Are you Pregnant? ☐ Yes ☐ No

date last period _____
# of pregnancies _____
# of miscarriages _____
# of abortions _____
date last PAP _____

- ☐ ☐ difficult labor
- ☐ ☐ breast problems

LOW BACK
- ☐ ☐ low back pain

Low Back pain is worse when:
- ☐ working
- ☐ lifting
- ☐ stooping
- ☐ standing
- ☐ sitting
- ☐ bending
- ☐ coughing

- ☐ ☐ slipped disk
- ☐ ☐ low back feels out of place
- ☐ ☐ muscle spasms
- ☐ ☐ arthritis

MID BACK
- ☐ ☐ mid back pain
- ☐ ☐ pain between shoulder blades
- ☐ ☐ sharp stabbing
- ☐ ☐ muscle spasms

SKIN
- ☐ ☐ easy bruising
- ☐ ☐ dry skin
- ☐ ☐ itching
- ☐ ☐ boils
- ☐ ☐ rashes
- ☐ ☐ excessive sweat
- ☐ ☐ hair changes

EENT
PAST NOW
- ☐ ☐ earache
- ☐ ☐ ear discharge
- ☐ ☐ ringing in ears
- ☐ ☐ hearing loss
- ☐ ☐ nosebleeds
- ☐ ☐ hoarseness
- ☐ ☐ problems swallowing
- ☐ ☐ sore throat
- ☐ ☐ jaw tight or sore
- ☐ ☐ dental problems
- ☐ ☐ glasses/contacts
- ☐ ☐ dentures

MUSCULOSKELETAL
- ☐ ☐ joint swelling
- ☐ ☐ muscle cramps
- ☐ ☐ neck pain
- ☐ ☐ shoulder pain
- ☐ ☐ elbow pain
- ☐ ☐ arm pain
- ☐ ☐ hand sensations
- ☐ ☐ midback pain
- ☐ ☐ rib pain
- ☐ ☐ low back problems
- ☐ ☐ hip pain
- ☐ ☐ foot problems
- ☐ ☐ leg cramps
- ☐ ☐ knee pain
- ☐ ☐ ankle weakness
- ☐ ☐ tingling foot

SHOULDERS
- ☐ ☐ pain in shoulder joint
- ☐ ☐ pain across shoulders
- ☐ ☐ bursitis (R-L)
- ☐ ☐ arthritis (R-L)
- ☐ ☐ Can't raise arm:
  - ☐ above shoulder level
  - ☐ over head
- ☐ ☐ tension in shoulders
- ☐ ☐ muscle spasms (R-L)

ARMS & HANDS
- ☐ ☐ pain in upper arm
- ☐ ☐ pain in forearm
- ☐ ☐ pain in hands
- ☐ ☐ pain in fingers
- ☐ ☐ pins & needles in arms
- ☐ ☐ pins & needles in fingers
- ☐ ☐ fingers go to sleep
- ☐ ☐ hands cold
- ☐ ☐ swollen joints in fingers
- ☐ ☐ arthritis in fingers
- ☐ ☐ loss of grip strength ☐ right ☐ left
- ☐ ☐ numbness in arm ☐ right ☐ left
- ☐ ☐ numbness in hand ☐ right ☐ left

HEART/LUNG
PAST NOW
- ☐ ☐ chest pain
- ☐ ☐ high blood pressure
- ☐ ☐ low blood pressure
- ☐ ☐ persistent cough
- ☐ ☐ hard to breathe
- ☐ ☐ coughing blood
- ☐ ☐ coughing phlegm
- ☐ ☐ irregular heartbeat
- ☐ ☐ varicose veins
- ☐ ☐ ankle swelling

HEAD
- ☐ ☐ headache
  - ☐ entire head
  - ☐ back of head
  - ☐ forehead
  - ☐ temples
  - ☐ migraine
- ☐ ☐ head feels heavy
- ☐ ☐ loss of memory
- ☐ ☐ light-headedness
- ☐ ☐ fainting
- ☐ ☐ light bothers eyes
- ☐ ☐ loss of smell
- ☐ ☐ loss of taste
- ☐ ☐ loss of balance
- ☐ ☐ dizziness
- ☐ ☐ loss of hearing
- ☐ ☐ pain in ears

NECK
- ☐ ☐ pain in neck
- ☐ ☐ neck pain with movement
- ☐ ☐ neck feels out of place
- ☐ ☐ stiff neck
- ☐ ☐ muscle spasms in neck
- ☐ ☐ grinding sounds in neck
- ☐ ☐ grating sounds in neck
- ☐ ☐ popping sounds in neck
- ☐ ☐ arthritis in neck

HIPS, LEGS & FEET
- ☐ ☐ pain in buttocks (R-L)
- ☐ ☐ pain in hip joint (R-L)
- ☐ ☐ pain down leg (R-L)
- ☐ ☐ pain down both legs
- ☐ ☐ leg cramps
- ☐ ☐ pins & needles in legs
- ☐ ☐ numbness of leg (R-L)
- ☐ ☐ numbness of feet (R-L)
- ☐ ☐ numbness of toes
- ☐ ☐ feet feel cold
- ☐ ☐ cramps in feet (R-L)
- ☐ ☐ swollen ankles (R-L)
- ☐ ☐ swollen feet (R-L)
- ☐ ☐ painful joints in toes
- ☐ ☐ pain in foot (R-L)
- ☐ ☐ pain in knee (R-L)

1. Date of your last physical examination _____

2. Are you CURRENTLY receiving care from a ☐ Chiropractor ☐ Acupuncturist ☐ Medical ☐ Dentist ☐ Physical Therapist ☐ Massage Therapist ☐ Nutritionist ☐ Other _____

3. Who are you seeing and why? _____

4. What results did you get? _____

5. What medications have you taken within the last 2 months (Include over-the-counter drugs, vitamins, herbs, etc.) _____

_____

FAMILY HISTORY

1. Has your father or mother ever had:

☐ Alcoholism
☐ Allergies
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Cancer
☐ Diabetes
☐ Drug problem
☐ Emphysemia
☐ Epilepsy/Seizures
☐ Glaucoma
☐ Heart Trouble
☐ High blood pressure
☐ Kidney disease
☐ Mental disorder
☐ Scoliosis
☐ Stroke
☐ Thyroid disease
☐ Tuberculosis
☐ Ulcers
☐ Other _____
_____
_____

Are both parents living? ☐ Yes ☐ No
☐ Mother - Age_____
Cause of death _____
_____
☐ Father - Age_____
Cause of death _____
_____

NUTRITIONAL EVALUATION

1. List some of your favorite foods _____

2. Do you: ☐ Skip breakfast ☐ Eat a snack ☐ Eat a hearty breakfast

3. How many meals a day do you eat? _____ When is your biggest meal? _____

4. Do you eat when you are worried or rushed? ☐ Yes ☐ No How often? _____

5. Do you plan your meals according to the "Four basic food groups"? ☐ Yes ☐ No

6. DO YOU: Eat raw fruits or vegetables at least twice a day? ☐ Yes ☐ No
Eat green or yellow vegetables at least twice a day? ☐ Yes ☐ No
Eat frequently between meals? ☐ Yes ☐ No
Chew your food thoroughly before swallowing it? ☐ Yes ☐ No
Drink juice, milk or other drinks instead of water when thirsty? ☐ Yes ☐ No
Always add salt at the table? ☐ Yes ☐ No
Eat meat or dairy products 2 or more times a day? ☐ Yes ☐ No
Eat the same foods almost every day? ☐ Yes ☐ No
Eat when you are not hungry? ☐ Yes ☐ No
Eat until you feel full? ☐ Yes ☐ No
Occasionally go on a "crash" diet? ☐ Yes ☐ No
Always buy the cheapest foods? ☐ Yes ☐ No

7. Check below the types of foods you normally eat each day:

☐ Non foods: beverages etc.
☐ Desserts, candies, pastries, etc.
☐ Products made from white flour
☐ Products containing sugar
☐ Products containing chemical additives
☐ Processed meats: luncheon meats, bacon, etc.
☐ Ordinary, treated, commercial meats
☐ Processed (pasturized) milk and its products
☐ Commercially canned fruits and vegetables
☐ Commercially frozen fruits and vegetables
☐ Commercial nuts
☐ Pure, natural, untreated meats
☐ Raw milk and its unprocessed products
☐ Healthy, home canned fruits and vegetables
☐ Healthy, home frozen fruits and vegetables
☐ 100% grain products
☐ Common, fresh, cooked fruits and vegetables
☐ Organic, fresh, cooked fruits and vegetables
☐ Sprouts
☐ Fresh, organic nuts
☐ Common, fresh, raw fruits and vegetables
☐ Organic, fresh, raw fruits and vegetables

8. Do you use: Alcohol? ☐ Yes ☐ No Amount per week _____ Type _____
Tobacco? ☐ Yes ☐ No Packs per day _____ How many years _____
Coffee? ☐ Yes ☐ No Cups a day _____
Carbonated drinks? (Pepsi, Coca Cola, etc.) ☐ Yes ☐ No Per day _____

9. How many glasses of water do you drink a day? _____ ☐ Filtered ☐ Bottled

ENVIRONMENTAL EVALUATION

1. Do you react to any chemicals, cosmetics, household cleaners, smoke, fabrics, etc.? ☐ Yes ☐ No If yes, list _____
2. Check any of the following items you are exposed to or use:

☐ Aluminum cookware
☐ Teflon cookware
☐ Microwave oven
☐ Computer terminal
Hours per day _____
☐ Flourescent lights
Hours per day _____
☐ Secondhand cigarette smoke
☐ Periodic high noise levels
☐ Drugs? ☐ Recreational ☐ Prescription When _____
List _____

☐ Continuous background noise
☐ Synthetic fibers
☐ Heavy metals (Lead, mercury, asbestos, etc.)
List _____
☐ Toxic chemicals (pesticides, Dioxin, Radioactive, PCB, etc.) List _____
☐ Electric blanket

3. Do you live near:

☐ A freeway or busy street
☐ Major powerline or electric substation
☐ Radio or TV transmission tower
☐ Toxic waste site
☐ Airport
☐ Nuclear reactor
☐ Major industry
What kind _____

4. Do you like your neighborhood? ☐ Yes ☐ No
5. Is your home:

Heated with ☐ Electricity ☐ Gas ☐ Wood Other _____
☐ Hot ☐ Cold ☐ Light ☐ Dark ☐ Drafty ☐ Damp ☐ Relaxing
☐ Tense ☐ New ☐ Old ☐ Safe ☐ Noisy ☐ Recently remodelled
Other _____

LIFESTYLE EVALUATION

1. Occupation _____ Position held _____
How long? _____ Do you like your job? ☐ Yes ☐ No
2. Do you have any job problems? ☐ Yes ☐ No If yes, what? _____
3. Do you have financial worries? ☐ Yes ☐ No
4. School: ☐ Finished grade _____ ☐ Finished high school ☐ Other _____
5. What are your hobbies/interests? List _____
6. How many hours a day do you watch TV? _____ Your favorite shows? _____
7. Do you have stress in your life? ☐ Yes ☐ No If yes, what causes the stress? _____
8. Is your energy level ☐ High ☐ Low ☐ Up and Down
9. Do you exercise? ☐ Yes ☐ No ☐ If yes, how many days a week? _____ Type of exercise? _____
☐ Outdoors ☐ Indoors ☐ Regularly ☐ Occasionally ☐ Never
10. How many hours do you sleep at night? _____ Usual bedtime _____
Usual time you get up _____ Do you feel rested when you get up ☐ Yes ☐ No
11. How often do you take naps? _____ How often do you wake up at night? _____
12. How long have you been with your spouse? _____
13. Please indicate approximate dates and briefly describe the nature of any traumatic experience you have had (e.g. divorce, injury, death in family, change of residence, bankruptcy, etc.) _____
14. What is the most important health change you would like to occur? _____
15. How do you feel about yourself? ☐ Very good ☐ Good ☐ Fair ☐ Not good
16. What would you like to change about yourself? _____
17. How many hours do you spend alone? _____ Do you enjoy being alone? ☐ Yes ☐ No
18. What is your religious upbringing? _____ Religious faith now? _____
19. What is your religious practice? ☐ Prayer ☐ Meditation Other _____
How often? _____ How important is this to you? _____

Patients signature _____