

HEALTH QUESTIONNAIRE

Please indicate for each of the questions below your experience by use of one of the following codes

1 – **NEVER** had

2 – **PREVIOUSLY** had

3 – **PRESENTLY** have

MUSCULO-SKELETAL SYSTEM

- ___ Low back problems
- ___ Pain between shoulders
- ___ Neck problems
- ___ Arm problems
- ___ Leg problems
- ___ Swollen joints
- ___ Painful joints
- ___ Stiff joints
- ___ Sore muscles
- ___ Weak muscles
- ___ Walking problems
- ___ Ruptures
- ___ Broken bones

GENITO-URINARY SYSTEM

- ___ Bladder trouble
- ___ Excessive urine
- ___ Scanty urination
- ___ Painful urination
- ___ Discoloured urine

FEMALE SYSTEM

- ___ Vaginal discharge
- ___ Vaginal bleeding
- ___ Vaginal pain
- ___ Breast pain
- ___ Lumps on breast

GASTRO-INTESTINAL SYSTEM

- ___ Poor appetite
- ___ Excessive hunger
- ___ Difficult chewing
- ___ Difficult swallowing
- ___ Excessive thirst
- ___ Nausea
- ___ Vomiting food
- ___ Vomiting blood
- ___ Abdominal pain
- ___ Diarrhea
- ___ Constipation
- ___ Black stool
- ___ Bloody stool
- ___ Hemorrhoids
- ___ Liver trouble
- ___ Gall bladder problems
- ___ Weight trouble

CARDIO-VASCULAR-RESPIRATORY SYSTEM

- ___ Chest pain
- ___ Pain over heart
- ___ Difficult breathing
- ___ Persistent cough
- ___ Coughing phlegm
- ___ Coughing blood
- ___ Rapid heartbeat
- ___ Blood pressure problems
- ___ Heart problems
- ___ Lung problems
- ___ Varicose veins

EYE, EAR, NOSE & THROAT

- ___ Eye strain
- ___ Eye inflammation
- ___ Vision problems
- ___ Ear pain
- ___ Ear noises
- ___ Hearing loss
- ___ Ear discharge
- ___ Nose pain
- ___ Nose bleeding
- ___ Nose discharge
- ___ Difficult breathing thru nose
- ___ Sore gums
- ___ Dental problems
- ___ Sore mouth
- ___ Hoarseness
- ___ Difficult speech

NERVOUS SYSTEM

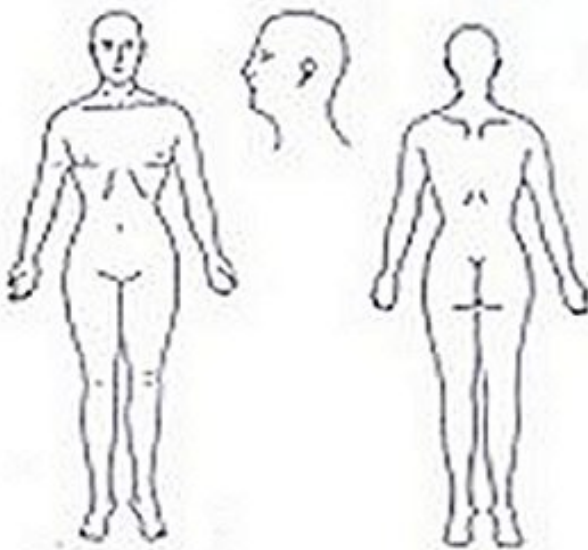
- ___ Numbness
- ___ Loss of feeling
- ___ Paralysis
- ___ Dizziness
- ___ Fainting
- ___ Headaches
- ___ Muscle jerking
- ___ Convulsions
- ___ Forgetfulness
- ___ Confusion
- ___ Depression

Please mark your areas of pain on the figures shown below

○ - GENERAL PAIN AREA

X - SITE OF PAIN

→ - IF PAIN RADIATES



HABITS	HEAVY	MODERATE	LIGHT	NONE
Alcohol	___	___	___	___
Coffee	___	___	___	___
Tobacco	___	___	___	___
Medication	___	___	___	___
Sleep	___	___	___	___
Appetite	___	___	___	___

Are you taking Vitamins or Minerals? ___ Yes ___ No Which ones? _____

Indicate the type and frequency of **exercise** you do

FREQUENCY

- ___ **STRETCH** _____
- ___ **STRENGTH** _____
- ___ **CARDIO** _____

Are you wearing _____ Heel lifts _____ Arch supports _____

Dated this _____ day of _____, 200__

Patient Signature

Verification of Signature