

## Health Questionnaire

Please indicate for each of the question below, your experience by use of one of the following codes.

Codes: 1 for never had; 2 for previously had; 3 for presently have.

### MUSCULO- SKELETAL SYSTEM

#### CODE

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

### GENITO- URINARY SYSTEM

#### CODE

- ☐ Bladder trouble
- ☐ Excessive urine
- ☐ Scanty urine
- ☐ Painful urination
- ☐ Discolored urine

### FEMALE CODE

- ☐ Vaginal Discharge
- ☐ Vaginal bleeding
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps on breast

### GASTRO-INTESTINAL SYSTEM

#### CODE

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Difficulty chewing
- ☐ Difficulty swallowing
- ☐ Nausea
- ☐ Vomiting food
- ☐ Vomiting blood
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder problems
- ☐ Weight gain/loss

### NERVOUS SYSTEM

#### CODE

- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscle jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression

### CARDIO-VASCULAR- RES-PIRATORY

#### CODE

- ☐ Chest pain
- ☐ Heart pain
- ☐ Rapid heart beat
- ☐ Blood pressure high/low
- ☐ Heart problems
- ☐ Difficult breathing
- ☐ Persistent cough
- ☐ Coughing up phlegm
- ☐ Coughing up blood
- ☐ Lung problems
- ☐ Varicose veins

### EYE, EAR, NOSE AND THROAT

#### CODE

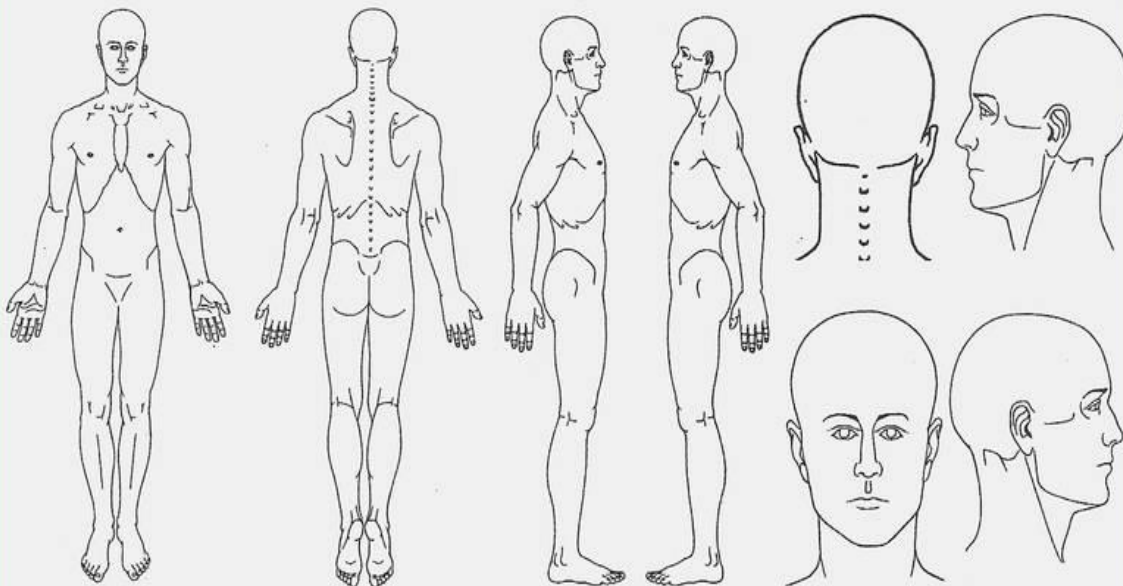
- ☐ Eye strain
- ☐ Eye inflammation
- ☐ Vision problems
- ☐ Ear pain
- ☐ Ear noises
- ☐ Hearing loss
- ☐ Ear discharge
- ☐ Nose pain
- ☐ Nose Bleeding
- ☐ Nose Discharge
- ☐ Difficult breathing through nose
- ☐ Sore gums
- ☐ Dental problems
- ☐ Sore mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficult speech

**Please indicate the location and sensation of your body pain using the following symbols:**

^ ^ ^ ^ ^ Numbness  
o o o o o Pins and Needles

x x x x x Burning  
\* \* \* \* \* Aching/Dull

///// Stabbing/Sharp  
EEEEEE Electrical



I understand that the doctor and the clinic staff have access to my health records for providing care. I am also assured that any information I provide is kept confidential. Therefore, I authorize the use of the above information as described.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**Your referrals are most welcomed.**