Chiropractic Center of Los Angeles

Confidential Health Questionnaire

Please indicate for each of the groups below your experience by using of one of the following codes:

1 = If you have PREVIOUSLY HAD 2 = If you PRESENTLY HAVE

MUSCULO-SKELETAL SYSTEM

___ Low Back Pain
___ Pain between Shoulders
___ Neck Pain
___ Arm Pain
___ Leg Pain
___ Swollen Joints
At what time of day? _____
___ Painful Joints
Which Joints? _____
___ Redness/Heat of any Joint
___ Stiff Joints
___ Sore Muscles
___ Tingling of Hands or Feet
___ Weak Muscles
___ Leg Cramps
___ Arthritis
___ Broken Bones
Which bones? _____
___ Bursitis
___ Sciatica
___ Polio or Meningitis

GASTRO-INTESTINAL SYSTEM

___ Poor Appetite
___ Excessive Hunger
___ Difficulty Chewing
___ Excessive Thirst
___ Nausea
___ Vomiting Food
___ Vomiting Blood
___ Abdominal Pain
___ Colitis/Bowel Disease
___ Diarrhea
___ Constipation
___ Black Stool
___ Bloody Stool
___ Hemorrhoids
___ Liver Trouble
___ Gall Bladder Problems
___ Weight Trouble
___ Anemia

FEMALE

___ Vaginal Discharge
___ Vaginal Bleeding
___ Vaginal Pain
___ Breast Pain
___ Lumps in Breast
___ Pregnant Now ___ Months

GENITO-URINARY SYSTEM

___ Bladder Trouble
___ Excessive Urination
___ Scanty Urination
___ Painful Urination
___ Discolored Urine
___ Gonorrhea or Syphilis
___ Lose Urine on Cough/Sneeze

CARDIO-VASCULAR/RESPIRATORY

___ Chest Pain
___ Pain over Heart
___ Angina Pectoris
___ Difficulty Breathing
___ Persistent Cough
___ Coughing Phlegm
___ Coughing Blood
___ Chronic or Frequent Cough
___ Rapid Heartbeat
___ Blood Pressure Problems
___ Heart Problems
___ Lung Problems
___ Tuberculosis
___ Varicose Veins
___ Rheumatic Fever

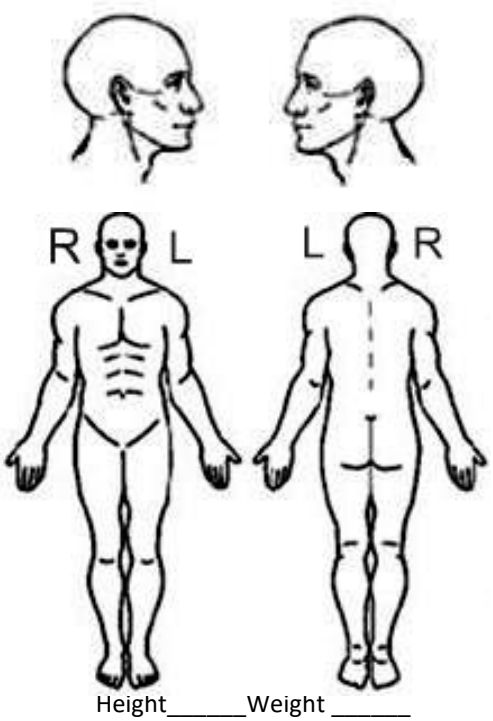
NERVOUS SYSTEM

___ Numbness
Where? _____
___ Fatigue without reason
___ Paralysis
___ Stroke
___ Dizziness
___ Fainting
___ Headaches
___ Muscle Twitching/Spasms
___ Muscle Spasms
___ Convulsions
___ Forgetfulness
___ Confusion
___ Depression
___ Neuritis/Neuralgia
___ Night Sweats
___ Inability to Stand Heat
___ Inability to Stand Cold
___ Skin Rashes

EYE, EAR, NOSE & THROAT

___ Eye Strain
___ Eye Inflammation
___ Vision Problems
___ Ear Pain
___ Hearing Loss
___ Ringing in Ears
___ Ear Discharge
___ Growths in Neck/Throat
___ Nose Pain
___ Nose Discharge
___ Nose Bleeding
___ Difficulty Breathing thru nose
___ Sinus Problems
___ Sore Gums
___ Dental Problems
___ Sore Mouth
___ Difficulty Swallowing
___ Hoarseness
___ Difficult Speech
___ Hay Fever
___ Asthma
___ Strange Taste/Loss of Taste

Please mark your areas of pain on the figures below.



How many bed pillows do you use? _____

Any history of Cancer? Yourself ____ Family _____ Height_____Weight _____

Have you ever been advised to have any surgical operation which has not been done? (Give details) _____

Have you ever been hospitalized for any illness? (Give details) _____