

Personal Health Questionnaire

Please indicate with a check mark any areas that are currently bothering you, or have been a significant problem in the past.

Musculoskeletal System

- Headaches
- Neck Pain
- Arm Pain / Numbness
- Pain Between the Shoulders
- Mid Back Pain
- Low Back pain
- Leg pain / Numbness
- Swollen Joints
- Stiff Painful Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Broken Bones

Nervous System

- Numbness
- Loss of Feeling
- Paralysis
- Dizziness / Vertigo
- Fainting
- Convulsions
- Forgetfulness
- Depression

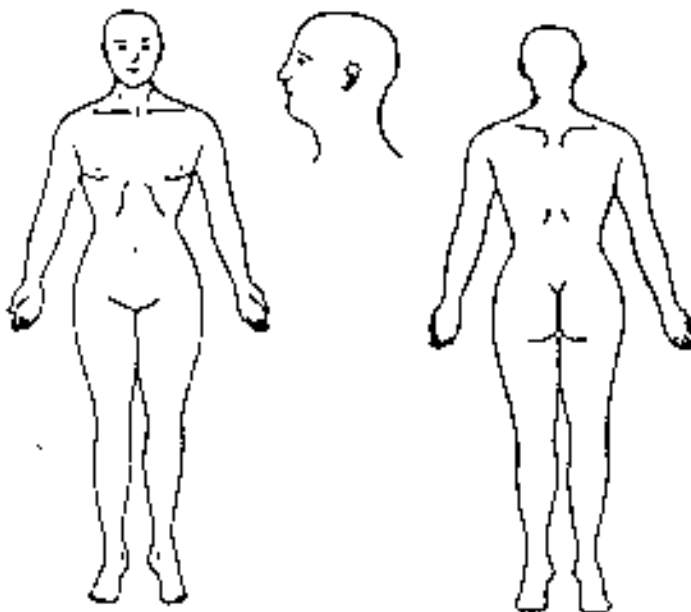
Female

- Breast Pain
- Lumps in Breast
- Vaginal Pain
- Pregnant / May be

Gastrointestinal System

- Poor Appetite
- Excessive Hunger
- Difficulty Chewing
- Difficulty Swallowing
- Excessive Thirst
- Nausea
- Vomiting
- Abdominal Pain
- Constipation
- Diarrhea
- Liver Problems
- Gall Bladder Problems
- Weight Problems

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW



Cardio-Vascular-Respiratory

- Chest Pain
- Difficult Breathing
- Persistent Cough
- C.V.A./ Stroke
- Heart Problems
- Lung Problems
- T.I.A.'s
- Aneurysm

Eye-Ear-Nose-Throat

- Vision Problems
- Eye Inflammation
- Ear Pain
- Ringing in Ears
- Ear Discharge
- Hearing Loss
- Nose Pain
- Excessive Discharge
- Sore Mouth or Gums
- Jaw Pain or Clicking
- Grind Teeth
- Dental Problems
- Hoarseness
- Difficult Speech

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged to me and that I am personally responsible for payment. I also understand any services rendered are with my consent and approval.

Signature: _____