

Health History Questionnaire

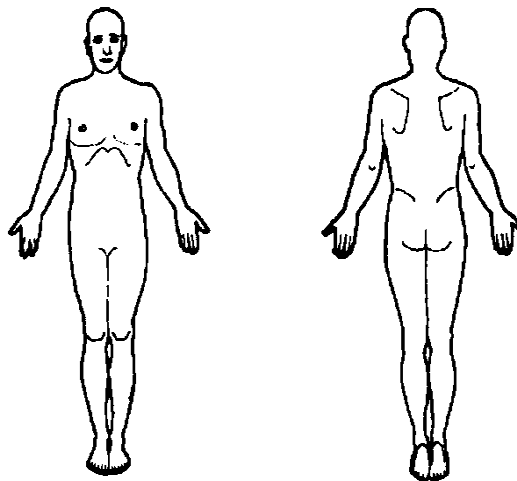
Patient name _____

Date _____

Have you ever been diagnosed or told you have any of the following? Circle the correct response.

- | | | |
|---|-----|----|
| 1. High blood pressure ----- | Yes | No |
| 2. Hardening of the arteries (arteriosclerosis)----- | Yes | No |
| 3. Diabetes----- | Yes | No |
| 4. Tuberculosis----- | Yes | No |
| 5. Cancer ----- | Yes | No |
| Where? _____ | | |
| 6. Heart or blood diseases ----- | Yes | No |
| 7. Bone spurs on the neck bones (cervical sprain)----- | Yes | No |
| 8. Whiplash injury (flexion-extension injury, cervical sprain) ----- | Yes | No |
| 9. Have you or any of your relatives ever suffered a stroke? ----- | Yes | No |
| 10. Were you ever a smoker? ----- | Yes | No |
| From _____ to _____ | | |
| 11. Do you take medication on a regular basis? ----- | Yes | No |
| 12. Visual disturbances (blurring, loss, double vision)----- | Yes | No |
| 13. Hearing disturbances (loss, ringing, other noise) ----- | Yes | No |
| 14. Slurred speech or other speech problems ----- | Yes | No |
| 15. Difficulty swallowing ----- | Yes | No |
| 16. Dizziness ----- | Yes | No |
| 17. Loss of consciousness, even momentary blackouts ----- | Yes | No |
| 18. Numbness, loss of sensation, loss of strength or weakness in the face,
fingers, hands, arms, legs, or any other parts of the body? ----- | Yes | No |
| 19. Sudden collapse without loss of consciousness----- | Yes | No |

Indicate the location of your pain by shading in the appropriate area(s):



Indicate the severity of the pain by checking a number:

| 0 1 2 3 4 5 6 7 8 9 10 |
 No pain Extreme pain