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

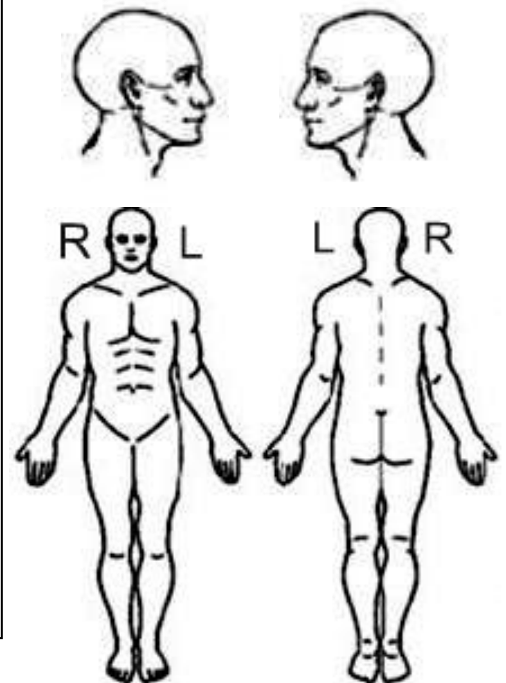
NERVOUS SYSTEM

- ___ 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 ______

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) ____