

# 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

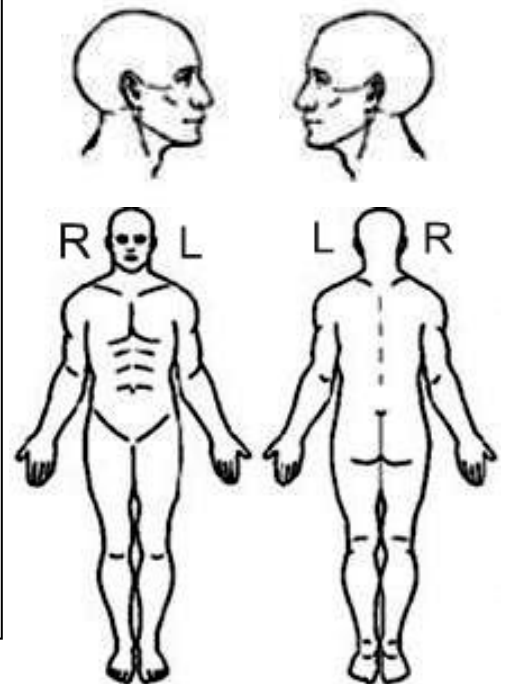
Difficult Speech

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) \_\_\_\_\_