Health History Questionnaire

Name: _____

Have you ever been diagnosed or told you have any of the following?

1. High blood pressure *
- Yes
- No

2. Hardening of arteries(arteriosclerosis) *
- Yes
- No

3. Diabetes *
- Yes
- No

4. Tuberculosis *
- Yes
- No

5. Cancer, Where? *
- Yes
- No

6. Heart or blood disease *
- 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 every suffered a stroke? *
- Yes
- No

10. Were you ever a smoker? From _____ to_____ *
- Yes
- No

11. Do you take any medication on a regular basis? *
- Yes
- No

12. Visual disturbances(blurring, loss, double) *
- 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, 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 sverity of the pain
- 0 --- No Pain
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 --- Extreme Pain

Indicate the location of your pain by shading in the appropriate area