

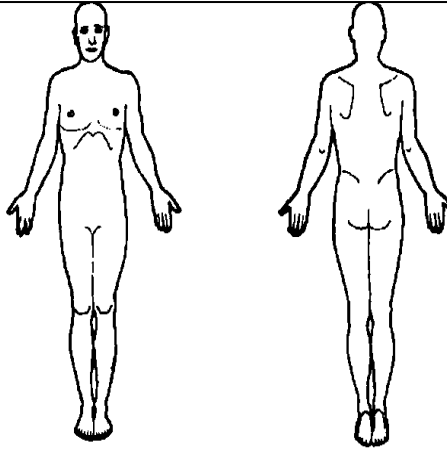
HEALTH HISTORY QUESTIONNAIRE

Name: _____

Have you ever been diagnosed or told you have any of the following?
Please 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, Where? | Yes | No |
| 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? 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 location of your pain by
shading in the appropriate area



Indicate the severity of the pain by circling a number.

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