CHIROPRACTIC INTERNIST
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PATIENT DIAGNOSTIC QUESTIONNAIRE

NAME:_____ How old are you?_____Today's Date:_____

YOUR CHIEF COMPLAINTS

Please Mark with an (X) the principle or major conditions which you are concerned about, would like eliminated, or desire for treatment for:

002 ( ) Overweight
003 ( ) Underweight
004 ( ) Sexual Problems
005 ( ) Menopause Problems
006 ( ) Heart Condition
007 ( ) Blood Pressure Problems
008 ( ) Digestion Trouble
009 ( ) Gall Bladder Problems
010 ( ) Diabetes Mellitus
011 ( ) Skin Disorder
012 ( ) Ear or Hearing Disorder
013 ( ) Sinus Infections
014 ( ) Nervous/Emotional Trouble
015 ( ) Allergies to Food
016 ( ) Nutritional Evaluation
017 ( ) Arthritis/Rheumatism
018 ( ) Headaches
019 ( ) Female Problems
020 ( ) Extreme Fatigue
021 ( ) Cancer
022 ( ) Circulatory Problems
023 ( ) Lung and/or Breathing
024 ( ) Stomach and/or Gall Bladder
025 ( ) Intestine or Bowel Troubles
026 ( ) Neck and/or Spine Problems
027 ( ) Eye Condition
028 ( ) Nose/Throat/Mouth Problems
029 ( ) Dizziness/Balance Disorder
030 ( ) Kidney/Bladder/Urinary
031 ( ) Allergies in General
032 ( ) Thorough Diagnostic Checkup
033 ( ) Alcohol or Tobacco Addiction

PLEASE FOLLOW THESE INSTRUCTIONS CAREFULLY WHEN COMPLETING THIS QUESTIONNAIRE:
Read each question carefully and mark with an (X) only those statements which are true for you (a yes answer)
If a question does not apply to you, or you do not recognize the terminology or disease, or if you are not sure and have a doubt about a question, then do not check the box, simply leave it blank ( ).

General

034 ( ) Are you overweight?
035 ( ) Are you underweight?
036 ( ) Are your fingernails ridged or have white spots?
037 ( ) Do you sleep less than seven hours per night?
038 ( ) Do you rarely exercise?
039 ( ) Do you smoke over 9 cigarettes each day or inhale pipe/cigars?
040 ( ) Do you drink alcoholic beverages each day?
041 ( ) Do you usually drink less than 8 glasses of water each day?
042 ( ) Are you sensitive to chemicals, paint, exhaust fumes, cologne?
043 ( ) Are you unable to recall your dreams the next day?

Eyes

044 ( ) Are you near sighted (can't see things at a distance)?
045 ( ) Are you far sighted (can't read small print without glasses)?
046 ( ) Do your eyes frequently itch?
047 ( ) Do you suffer from cross eyes?
048 ( ) Do you have or have you had cataracts?
049 ( ) Do you experience pain in your eyes?
050 ( ) Are your eyes bloodshot?
051 ( ) Do your eyes water?
052 ( ) Do your eyes feel gritty?
053 ( ) Is your vision blurred?
054 ( ) Are you hard of hearing?
055 ( ) Are you experiencing any discharge from your ears?
056 ( ) Do you have ringing or noises in your ears?
057 ( ) Do you suffer from recurrent ear infections?
058 ( ) Do you have a punctured ear drum?

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PATIENT DIAGNOSTIC QUESTIONNAIRE (cont'd)

MOUTH AND THROAT

059 ( ) Is your tongue badly coated?
060 ( ) Do you have bad breath?
061 ( ) Do you suffer from sores or cracks at the corners of your mouth?
062 ( ) Do you frequently experience canker sores (sore mouth)?
063 ( ) Are your gums sore?
064 ( ) Do you frequently suffer from fever blisters?
065 ( ) Do your gums bleed when you brush your teeth?
066 ( ) Do you have sore throats frequently?
067 ( ) Are your glands often swollen?
068 ( ) Do you suffer from toothaches?
069 ( ) Is your mouth often dry?
070 ( ) Do you have excessive saliva?
071 ( ) in the mornings, do you have a bitter taste in your mouth?
072 ( ) Do you frequently have a sore tongue?

RESPIRATORY

073 ( ) Do you have frequent colds?
074 ( ) Do you suffer from nasal polyps?
075 ( ) Do you often have sinus infections?
076 ( ) Do you experience night sweats?
077 ( ) Do you have hay fever?
078 ( ) Do you wheeze?
079 ( ) Do you have asthma?
080 ( ) Do you experience difficulty in breathing?
081 ( ) Do you have a chronic cough?
082 ( ) Do you spit up phlegm?
083 ( ) Do you spit up blood?
084 ( ) Do you have spells of sneezing?
085 ( ) Is your nose frequently stuffy?
086 ( ) Does your nose run constantly?
087 ( ) Do you have frequent nose bleeds?
088 ( ) Do you catch severe colds?
089 ( ) Do you have chronic chest condition?
090 ( ) Do you have post nasal drip?

CARDIOVASCULAR

091 ( ) Do you have high blood pressure?
092 ( ) Do you have low blood pressure?
093 ( ) Do you have pains in the heart or chest?
094 ( ) Are you troubled with blood clots?
095 ( ) Do you have cold hands?
096 ( ) Are your feet frequently cold?
097 ( ) Do you have varicose veins?
098 ( ) Are your ankles frequently swollen?
099 ( ) Do you have an unusually slow pulse rate?
100 ( ) Do you experience spells of rapid heart beat?
101 ( ) Are you aware of your heart skipping beats?
102 ( ) Do you experience shortness of breath while sitting st
103 ( ) Do you suffer from leg cramps after retiring to bed?
104 ( ) Do you suffer from leg cramps during the day?
105 ( ) Do you experience pain in your leg/hips when walking

GASTROINTESTINAL

106 ( ) Is your appetite poor?
107 ( ) Do you have excessive hunger?
108 ( ) Do you experience fainting spells when hungry?
109 ( ) Does eating relieve fatigue?
110 ( ) Do you feel shaky when hungry?
111 ( ) Are you frequently drowsy after eating?
112 ( ) Do you eat when nervous?
113 ( ) Do you frequently have diarrhea?
114 ( ) Do you have difficulty swallowing?
115 ( ) Do you vomit frequently?
116 ( ) Are you frequently nauseated?
117 ( ) Are you bloated after eating?
118 ( ) Do you have abdominal gas?
119 ( ) Does eating greasy foods cause you to have indegesti
120 ( ) Do you belch or burp after eating?
121 ( ) Do you have indigestion immediately after eating?
122 ( ) Do you have indigestion within 1 hour after meals?
123 ( ) Do you have indigestion within 2 hours or more after
124 ( ) Do you have loose bowel movements?
125 ( ) Have you ever had intestinal worms?
126 ( ) Do you have pale or yellow colored stools?
127 ( ) Do you suffer from constipation?
128 ( ) Do you have one or less bowel movements daily?
129 ( ) Are your stools bloody?

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130 ( ) Do you have black tarry stools?
131 ( ) Do you use laxatives?
132 ( ) Do you suffer from servere abdominal pains?
133 ( ) Do you have hemorrhoids (piles)?
134 ( ) Do you have stomach ulcers?
135 ( ) Do you have gall bladder disease?
136 ( ) do you have liver disease?

NEUROMUSCULAR

137 ( ) Do you have neck pain?
138 ( ) Do you have pain between the shoulders?
139 ( ) Do you suffer from low back pain?
140 ( ) Do you have swollen joints?
141 ( ) Do you have a spinal curvature?
142 ( ) Do you suffer from muscle spasms?
143 ( ) Are your muscles frequently sore?
144 ( ) Do you have muscle weakness?
145 ( ) Are your joints stiff in the morning?
146 ( ) Do you have shoulder/arm pain?
147 ( ) Do you suffer from leg pain at rest?
148 ( ) Do you have rheumatism?
149 ( ) Does any part of your body experience numbness/tingling?
150 ( ) Do you have frequent headaches?
151 ( ) Are you often dizzy?
152 ( ) Do you frequently feel faint?
153 ( ) Do you have epilepsy?
154 ( ) Do you bite your nails badly?
155 ( ) Do you stutter or stammer?
156 ( ) Are you a sleep walker?
157 ( ) Do you have rheumatoid arthritis?
158 ( ) Do you have osteoarthritis?
159 ( ) Do you suffer from motion sickness?

FEET

160 ( ) Do you suffer from painful feet?
161 ( ) Do you have frequent foot cramps?
162 ( ) Do you have plantar warts?
163 ( ) Do you have heel spurs?
164 ( ) Are you troubled with corns?

SKIN

165 ( ) Is your skin tender?
166 ( ) Does your skin itch?
167 ( ) Headaches
168 ( ) Female Problems
169 ( ) Extreme Fatigue
170 ( ) Cancer
171 ( ) Circulatory Problems
172 ( ) Lung and/or Breathing
173 ( ) Stomach and/or Gall Bladder
174 ( ) Intestine or Bowel Troubles
175 ( ) Neck and/or Spine Problems
176 ( ) Eye Condition
177 ( ) Nose/Throat/Mouth Problems
178 ( ) Dizziness/Balance Disorder

URINARY

179 ( ) Do you have frequent urination?
180 ( ) Do you awaken at night to urinate?
181 ( ) Are you a bed wetter?
182 ( ) Do you dribble when sneezing or laughing?
183 ( ) Have you ever lost control of your bladder?
184 ( ) Do you have painful urination?
185 ( ) Do you have blood in your urine?
186 ( ) Are you troubled by urgent urination?
187 ( ) Do you have difficulty in starting the stream?
188 ( ) Do you have frequent bladder infections?
189 ( ) Do you have frequent kidney infections?
190 ( ) Do you have kidney stones?

ENDOCRINE

191 ( ) Do you have excessive thirst?
192 ( ) Do you frequently feel cold?
193 ( ) Do you frequently feel hot?
194 ( ) Are you unusually tired most of the time?
195 ( ) Are you unusually jumpy or nervous?
196 ( ) Is your hair coarse?
197 ( ) is your skin coarse?
198 ( ) Are you diabetic?
199 ( ) Do you get lightheaded when standing quickly?

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PATIENT DIAGNOSTIC QUESTIONNAIRE (cont'd)

FOR WOMEN ONLY

200 ( ) Do you have painful periods?
201 ( ) Do you have excessive flow?
202 ( ) Do you have irregular cycles?
203 ( ) Do you suffer from menstrual cramps?
204 ( ) Do you have hot flashes?
205 ( ) Do you have vaginal discharge?
206 ( ) Do you have a bloody spotting discharge?
207 ( ) Have you had a hysterectomy?
208 ( ) Do you retain fluid during your periods?
209 ( ) Have you ever miscarried?
210 ( ) Do you have Acne worse at menstration?
211 ( ) Do you have tender breasts?
212 ( ) Do you have frequent yeast infections?
213 ( ) Do you have lumps in your breasts?
214 ( ) Do you have heavy hair growth on face or body?
215 ( ) Do you take birth control pills?
216 ( ) Do you have pre-menstrual depression?
217 ( ) Is intercourse painful for you?
218 ( ) Do you have a diminished sex desire?
219 ( ) Do you have pooer or infrequent orgasm?

FOR MEN ONLY

220 ( ) Do you have painful genitals?
221 ( ) Do you have prostate troubles?
222 ( ) Do you have lumps in your testicles?
223 ( ) Do you have a discharge from the urethra?
224 ( ) Do you have sores on external genitalia?
225 ( ) Do you have difficulty getting or keeping an erection?
226 ( ) Do you have difficulty completing intercourse?
227 ( ) Have you had difficulty fathering children?

BEHAVORIAL

228 ( ) Do you have difficulty falling asleep?
229 ( ) Do you have difficulty staying asleep?
230 ( ) Do you have recurrent bad dreams?
231 ( ) Do you have difficulty in concentrating?
232 ( ) Is your memory poor?
233 ( ) Do strange people or places make you afraid?
234 ( ) Are you scared to be alone?
235 ( ) Do you always need someone to advise you?
236 ( ) Are you afraid to eat anywhere except at home?
237 ( ) Are you unhappy when others are happy?
238 ( ) Are you usually unhappy and depressed?
239 ( ) Do you often cry?
240 ( ) Are you frequently miserable or blue?
241 ( ) Do you sometimes wish you were dead and away from it all?
242 ( ) Are your feelings easily hurt?
243 ( ) Does criticism always upset you?
244 ( ) Do people usually misunderstand you?
245 ( ) Do you have to be on guard even with your friends?
246 ( ) Do people often annoy you?
247 ( ) Are you easily angered?
248 ( ) Do you frequently become scared for no reason?
249 ( ) Do you feel you are under considerable emotional stress?

Thank you for completing this questionnaire.