

HEALTH EVALUATION

Date _____

Patient _____ No. _____

1. Do you have trouble relaxing or falling asleep? Yes No
2. Are you exhausted at the end of the day? Yes No
3. Do you have weight problems? Yes No If so,
Underweight? Yes No Overweight? Yes No
4. Do you take pain relievers, antacid, tranquilizers, or any other relief oriented medicine? Yes No
5. Do you exercise less than two times weekly? Yes No
6. Do you feel you are a nervous or tense person? Yes No
7. Do you lose your temper or become angry easily? Yes No
8. Do you rely on caffeine or sugar stimulants? Yes No
9. Have you ever had an auto accident or been injured on the job? Yes No
10. Do you have any other health problems of which you are aware? Yes No
If yes, explain, _____

PLEASE MARK YOUR AREAS OF PAIN AND/OR DISCOMFORT FOR THE ITEMS BELOW.

	Past	Present
Low back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder and Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>
Whiplash Neck Injuries	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Pinched Nerve	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or Tingling in Arms or Legs	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sinus or Allergies	<input type="checkbox"/>	<input type="checkbox"/>