The Applied Kinesiology Center

Comprehensive Form

Confidential Health Questionnaire ***Name___________________*** Date___________

Mark severity in past/now box from 1 to 3. (1-slight 2-moderate 3-severe)
please check box ( ) where appropriate.

Statistics:
Height:
Weight: now: ; one year ago: ;maximum: when?
Surgery: ovaries/uterus ( ) gallbladder ( ) appendix ( ) other ( )
Have you ever had X-rays of: back ( ) neck ( ) extremities ( ) organ ( )
other ( ) Have you ever had a MRI/CTScan?
Favorite Foods:
Allergies: Food or other:(list)
What foods do you crave and when?

Do You Use….	**Never**	**Rarely**	**Freq.**	**Daily**
Vitamins				
Laxatives				
Sedatives/tranquilizers				
Sleeping pills/Aids				
Aspirin, etc.				
Appetite drugs:				
Alcoholic Beverages				
Coffee/Tea cups per day:				
Soft Drinks				
Cigarettes packs per day:				
Cigars/Pipes ( ) Chewing tobacco ( )				
Recreational Drugs: Marijuana ( ) Other ( )				
Have you EVER tried any recreational drugs?				

Current Supplements/Medications (List)
Medications:Please include: Name/Reason for taking/Duration:
Vitamins/Minerals/Herbs:(list)

Part One: Musculo-Skeletal & Nervous System	**Past**	**Now**
Muscles: Sore ( ) aching ( ) weak ( ) tight ( )		

Muscles: cramps ( ) jerking ( ) bursitis ( )		
Arthritis: kind if known:		
Scoliosis		
Recurrent dislocations: (list)		
Any bone or joint Disease: (list)		
Broken Bones: (list)		
Other injuries		
Head Injuries:		
Loss of feeling/numbness/tingling		
Paralysis		
Convulsions/Seizures		
Headaches ( ) Migraines ( )		

Part Two: Digestive System & Abdomen		
Appetite: Poor ( ) excessive ( ) irregular ( )		
Change in: Appetite ( ) eating habits ( ) nausea ( )		
indigestion ( ) heartburn ( ) "nervous stomach" ( )		
ulcers ( ) belching/burping ( ) gas/flatulence ( )		
Abdominal: bloating ( ) pain ( )		
Vomiting: food ( ) blood ( ) bile ( )		
Stools: bloody ( ) black ( ) fatty ( )		
diarrhea ( ) constipation ( )		
Hemorrhoids:( ) bleeding ( ) piles ( )		
Rectal bleeding		
Parasites ( ) worms ( )		
Liver problems ( ) Hepatitis ( )		
Gall bladder problems ( ) Pancreas problems ( )		
Ulcers		
Hernia abdominal ( ) hiatal ( ) inguinal ( )		

Part Three: Heart and Circulation		
Chest Pain ( ) pain over heart ( )		
Heart Beat: rapid ( ) irregular ( ) slow ( )		
Heart Palpitations		
Other heart problems (describe):		
Blood Pressure: high ( ) low ( )		
Varicose veins		
general swelling/edema ( ) ankles ( ) feet ( )		
Pain in calf while walking		

Part Four: Skin, Hair & Nails		
Skin: Itchy ( ) sensitive ( ) rash ( )		
Bruise Easily		
Perspiration: excessive ( ) deficient ( )		
Nail Problems (describe):		
Premature gray hair		
Other hair/scalp problems (describe):		
Part Five: Reproductive System		
Vaginal: discharge ( ) excess bleeding ( ) pain ( )		
Breast: discharge ( ) tenderness ( ) lumps ( )		
Menstrual cramps front ( ) back ( ) both ( )		
Mood changes, menstrual cycle related		

Menopause problems ( ) Hot flashes ( )		
Menstrual flow: heavy ( ) medium ( ) low ( )		
Duration of period : ______days		
Length of cycle (start to start) :________days		
Date of last period (1st day)		
# of pregnancies: Number of children:		
Birth Control Method: Currently sexually active:		
Sexual difficulties (describe):		
Genital Lesions		
Hernia		
Testicles: pain ( ) mass or lump ( )		
Prostate problems		
erection problems ( ) ejaculation problems ( )		

Part Six: Kidney and Bladder		
Urination: Painful ( ) Frequent ( ) difficult ( )		
Hesitant/intermittent ( ) urgent ( )		
Urination at night		
Urine excessive ( ) scanty ( )		
Urine discolored ( ) bloody ( ) strong odor ( )		
infections ( ) discharge ( )		
Loss of bladder control		
Kidney Stones ( ) Other related problems:		

Part Seven: Respiratory System		
Breathing: difficult ( ) painful ( )		
Shortness of breath: on exertion ( ) at night ( )		
Persistent cough		
Coughing: phlegm ( ) blood ( )		
Wheezing or Asthma: on exertion ( ) at night ( )		
Hyperventilation		
Sinus congestion: not frequent ( ) chronic ( )		

Part Eight: Eye, Ear, Nose & Mouth		
Eyes: strain ( ) inflammation ( )		
Blurred Vision		
Other visual Problems (describe)		
Ears: pain ( ) ringing ( ) discharge ( )		
Loss of: Hearing ( ) Sight ( ) Taste ( ) Smell ( )		
Nose: Pain ( ) bleeding ( ) discharge ( )		
Difficulty breathing through nose: during day ( ) during night ( )		
Sore Throat		
Hoarseness		
Difficulty with: swallowing ( ) speech ( ) chewing ( ) teeth ( )		
Tongue problems (describe):		
Mouth: ulcers ( ) bad taste in mouth ( )		
Saliva: excessive ( ) deficient ( )		
Part Nine: Miscellaneous		
Have you ever been diagnosed as having: cancer ( ) diabetes ( )		
hypoglycemia ( ) sexually transmitted disease ( )		
Mono ( ) AIDS ( ) Epstein Barr ( )		
Thyroid Problems: hypo ( ) hyper ( )		
Other:		
Rapid Weight gain ( ) loss ( )		
Heat and cold intolerance ( ) cold hands and/or feet ( )		

Slow to heal ( )		
Excessive thirst ( ) Water retention ( ) Swollen glands ( )		
Tire easily ( ) general fatigue ( )		
Poor memory/concentration/thinking		
dizziness ( ) fainting ( ) fever ( ) chills ( )		
Night sweats ( ) shaky feeling ( )		
confusion ( ) irritable ( ) depression ( ) anxiety ( )		
Emotional crisis/breakdown ( ) Do you cry easily ( )		
Anemia		
Dehydration		

Part Ten: Personal Habits		
Do you sleep well?		
Awaken rested?		
Average hours of sleep per night:		
Bowel movements per day:		
Diarrhea ( ) Constipation ( )		
Sex - entirely satisfactory?		
Do you like your work? How many hours per day/week		
Hours of Television you average per day:		
Average time you read each day:		
Average time with a computer:		
Have you ever been treated for: Alcoholism ( ) Drug abuse ( )		
Do you exercise?What/How often:		
Hobbies:		

Part Eleven: Family History **Spouse**	**Mother**	**Father**	**Siblings**	**Children**
Check All Applicable and describe:				
Cancer				
Tuberculosis/TB				
Diabetes				
Heart Trouble				
High Blood Pressure				
Stroke				
Epilepsy				
Emotional Crisis				
Asthma, hives, hayfever				
Other				
Death (list cause and year)				