



COMPREHENSIVE HEALTHCARE, INC.

Health & Lifestyle Questionnaire

1. Name: _____ 2. Date: _____
3. Address _____

4. Phone Numbers (please circle preferred contact number)
 - a. Home: _____
 - b. Office: _____
 - c. Cell: _____
5. Confidential e-mail: _____
6. Confidential fax (to send you confidential medical information): _____
7. Sex: _____ Male _____ Female 8. Height: _____
9. Date of Birth: _____ 10. Age: _____
11. How would you rate your current health? _____ Poor _____ Average _____ Good _____ Excellent
12. What are your health related goals? _____
13. What are your most important expectations as a patient? _____

14. Please list any surgical procedures you have had (including plastic surgery), along with the approximate date: _____

15. Please list any history of trauma that you have experienced (car accidents, head injuries, broken bones, etc.): _____

16. Please list any drug allergies you have, along with the reaction you experienced: _____

17. Please list any exposure you have experienced to environmental risks: _____

18. Please list all the medications (prescription and/or over-the-coater) you are currently taking and for what condition: _____

19. Please list all supplements (vitamins, herbs, nutritional supplements) you are currently taking and for what condition: _____

20. Please describe any current recreational drug use: _____
21. Are you currently receiving?: Radiation Therapy Chemotherapy
 - a. If yes, for what?



COMPREHENSIVE HEALTHCARE, INC.

Initial Confidential Patient Case History

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O - OCCASIONAL
F - FREQUENT
C - CONSTANT

O F C

GENERAL

- Allergy
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Nervousness/depression
- Neuralgia
- Numbness
- Sweats
- Tremors

MUSCLE & JOINT

- Arthritis
- Bursitis
- Foot trouble
- Hernia
- Low back pain
- Lumbago
- Neck pain or stiffness
- Pain between shoulders
- Pain or numbness in:
 - Shoulders
 - Arms
 - Elbows
 - Hands
 - Hips
 - Legs
 - Knees
 - Feet
- Painful tail bone
- Poor posture
- Sciatica
- Spinal Curvature
- Swollen joints

O F C

GASTRO-INTESTINAL

- Belching or gas
- Colitis
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Distension of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

EYES, EARS, NOSE & THROAT

- Asthma
- Colds
- Crossed eyes
- Deafness
- Dental Decay
- Earache
- Ear discharge
- Ear noises
- Enlarged glands
- Enlarged thyroid
- Eye pain
- Failing vision
- Far sightedness
- Gum trouble
- Hay fever
- Hoarseness
- Nasal obstruction
- Near sightedness
- Nosebleeds
- Sinus infection
- Sore throat
- Tonsillitis

O F C

CARDIO-VASCULAR

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

RESPIRATORY

- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing

SKIN

- Boils
- Bruise easily
- Dryness
- Hives or allergy
- Itching
- Skin eruptions (rash)
- Varicose veins

GENITO-URINARY

- Bed-wetting
- Blood in urine
- Frequent urination
- Inability to control kidneys
- Kidney infection or stones
- Painful urination
- Prostate trouble
- Pus in urine

FOR WOMEN ONLY

- Cramps or backache
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Menopausal symptoms
- Painful menstruation
- Vaginal discharge

Yes No Are you pregnant?

HABITS

- | | Heavy | Moderate | Light | None |
|----------|--------------------------|--------------------------|--------------------------|--------------------------|
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Coffee | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tobacco | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Drugs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Appetite | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |