## GENERAL HEALTH QUESTIONNAIRE

Welcome to Jpm Chiropratica!
Please fill out the following health questionnaire completely.
All the information you provide is protected by professional confidentiality, respecting the current norms on Privacy.

Name..... Surname.....
Date and Place of birth..... Gender M F

Occupation.....
Current Address.....
Postal code..... City..... Province.....
Telephone number.....
E-mail address.....

I hereby give my consent to the treatment of sensitive information in relation to Art.13 del D. Lgs. n. 196/2003 for the "code for protection of personal data"

Signature

.....

## GENERAL HEALTH QUESTIONNAIRE

What is your chief complaint?

.....

.....

What was the onset of your symptom?

.....

.....

Could you locate precisely the site of your symptom/s on the chart below?

.....

.....

Have you seen any other health practitioner about this condition? Who?

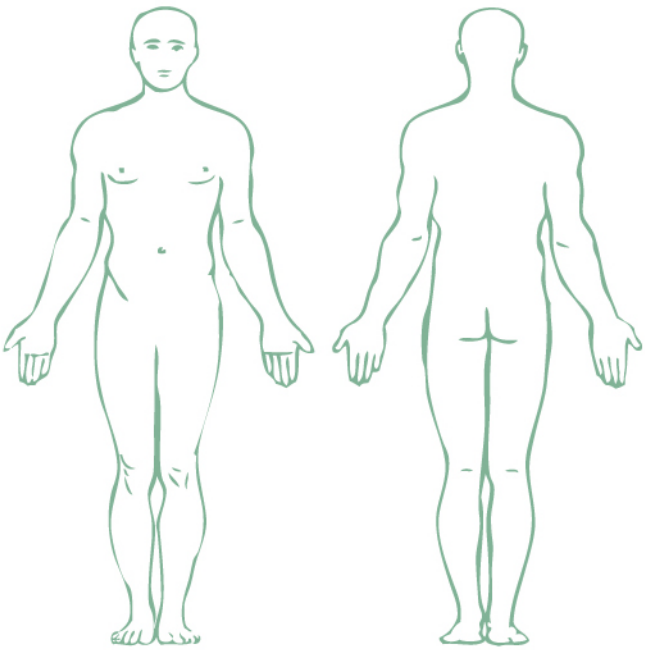
.....

.....

How long have you had this symptom?

.....

.....



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Please try to describe your pain (tingling/burning/stabbing...)

On a scale from 1 to 10, where 1 is no pain at all and 10 is the worst pain you can imagine, how would you rate your pain? .....

Is there anything you would like to add? .....

.....

## CLINICAL HISTORY

Have you ever had surgery?

.....

Have you ever had a general anesthetic?

.....

Have you ever experienced a fractured bone? If yes, where?

.....

Have you ever had an accident, experienced head trauma or loss of consciousness?

.....

Do you suffer of any preexisting condition?

.....

## DAILY HABITS

How much water do you drink each day?

.....

Do you eat a balanced diet?

.....

Do you know your height and weight?

.....

Do you drink any alcohol? How often?

.....

Do you smoke? How many cigarettes do you smoke per day?

.....

Do you practice any sports? Are you active?

.....

Do you sleep well at night?

.....

Do you think you have a stressful life?

.....

# GENERAL HEALTH QUESTIONNAIRE

Thank you for answering all these questions. There is one last part, that is very important to fill out: Please try and assess yourself from top to the bottom, and please try to remember if you feel or have felt in the past, any particular problems. This will help us help you best!

Do you suffer from headaches? Vertigo? Sinusitis?

Do you have any problems with your eyesight? Do you wear glasses or lenses?

Do you ever experience pain in your teeth/ jaw /tongue?

Do you suffer from Otitis, or have ear issues?

Do you frequently suffer from pain in your neck or throat?

Do you have any problems with your shoulders?

Do you have any difficulties breathing? Do you have any lung conditions?

Do you suffer from heart /vascular/lymphatic problems?

Do you suffer from pain in your knees/legs/ankles/feet?

Do you have any digestive problems?

Do you suffer from pain in your arms/elbows/wrists/hands?

Do you have any urinary or kidney problems?

Do you have any problems with your ovaries/uterus/ or gynecological in general?

Do you have any problems with your testicles or prostate?

Do you have any issues with your nervous system?

Please try to think if we may have left out anything that could be significant for your chiropractor to know:

Thank you! Your path at Jpm is about to start. If you have any questions or useful information, please contact our staff at the front desk, or the doctors that will be seeing you shortly.

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