Health Questionnaire
Please indicate for each of the questions below your experience by use of the following codes: 1-never had;2-previously had;3-presently have.

Musculo-Skeletal System
——— Low back problems
——— Pain between shoulders
——— Neck problems
——— Arm problems
——— Leg problems
——— Swollen Joints
——— Painful joints
——— Stiff joints
——— Sore muscles
——— Weak muscles
——— Walking problems
——— Ruptures
——— Broken bones

Genito-Urinary System
——— Bladder trouble
——— Excessive urination
——— Scanty urination
——— Painful urination
——— Discolored urine

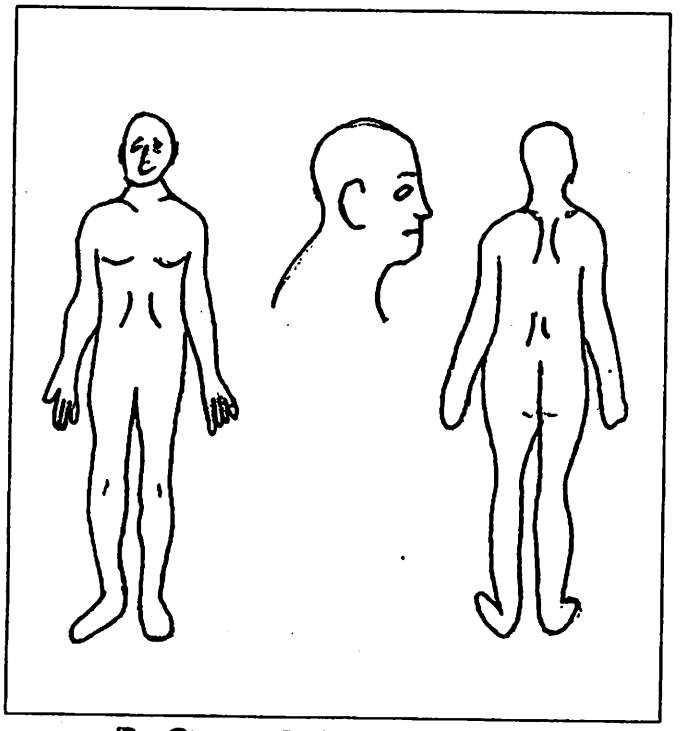
Female
——— Vaginal discharge
——— Vaginal bleeding
——— Vaginal pain
——— Breast pain
——— Lumps on breast
Are you pregnant?
❑ Yes ❑ No

Gastro-Intestinal System
——— Poor appetite
——— Excessive hunger
——— Difficult swallowing
——— Excessive thirst
——— Nausea
——— Vomiting blood
——— Vomiting food
——— Diarrhea
——— Constipation
——— Black stool
——— Bloody stool
——— Hemorrhoids
——— Liver trouble
——— Gall bladder problems
——— Weight trouble

Nervous system
——— Numbess
——— Loss of feeling
——— Paralysis
——— Dizziness
——— Fainting
——— Headaches
——— Muscle jerking
——— Convulsions
——— Forgetfulness
——— Confusios
——— Depression

Cardio-Vascular-Respiratory System
——— Chest pain
——— Pain over heart
——— Difficult breathing
——— Persistent cough
——— Coughing phlegm
——— Coughing blood
——— Rapid heartbeat
——— Blood pressure problems
——— Heart problems
——— Lung problems
——— Varicose veins

Eye,Ear,Nose,and Throat
——— Eye strain
——— Eye inflammation
——— Vision problems
——— Ear pain
——— Ear noises
——— Hearing loss
——— Ear discharge
——— Nose pain
——— Nose bleeding
——— Nose discharge
——— Difficult breathing thru nose
——— Sore gums
——— Dental problems
——— Sore mouth
——— Hoarseness
——— Difficult speech



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_____
Patients Signature

——— DO NOT WRITE BELOW THIS LINE ———

Patient accepted? ❑ Yes ❑ No Dr. Signature_____

Dr. George Rulli •

Workers' Compensation Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name_____ Sex_____ Marital Status_____ Date of Birth_____ Home Phone_____

Address_____ City_____ State_____ Zip_____

Occupation_____ Who referred you to our office?_____
[indicate if child, student, housewife, unemployed, retired]

Social Sec.#_____ Business Phone_____ Company Name_____ Location_____

Spouse's First Name_____ Spouse's Soc.Sec.#_____ Spouse's Employer_____ Location_____

Please explain in detail how your accident happened_____

_____

_____

_____

_____

Have you retained an attorney? ❑ Yes ❑ No Litigation? ❑ Yes ❑ No ❑ Maybe

If so, name and address_____

Give time and date present injury occurred_____ ❑ AM ❑ PM 19_____

Where did you feel pain immediately after the accident?_____

Did you return to work? ❑ Yes ❑ No If so, date returned to work_____

Did you consult any other doctor? ❑ Yes ❑ No

If so, give doctor's name_____ ❑ D.C. ❑ M.D. ❑ D.O. ❑ D.D.S.

Doctor's diagnosis_____

What treatments did you receive?_____

Have you ever injured this area before? ❑ Yes ❑ No If so,when?_____

If injured before, did you lose time from work? ❑ Yes ❑ No

If you lost time from work with injuries prior to this injury, give name of doctor or doctors consulted

_____

_____

Do any other diseases or accidents affect your employment? ❑ Yes ❑ No If so, explain_____

_____

_____

In your work do you have to favor any part of your body? ❑ Yes ❑ No If so,explain_____

_____

Do you have a history of absenteeism caused from accidents on the job? ❑ Yes ❑ No

Have you ever had a Workmen's Compensation claim before? ❑ Yes ❑ No

Before the injury were you capable of working on an equal basis with others your age? ❑ Yes ❑ No

Are your work activities restricted as a result of this accident? ❑ Yes ❑ No

Since this injury are your symptoms ❑ improving ❑ getting worse ❑ the same