

HEALTH ANALYSIS

No. _____ Date: _____

Patient _____ Home Phone () _____

Address _____ City _____ St _____ Zip _____

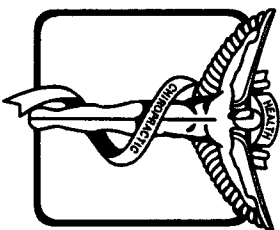
Marital Status Single Married Widowed Separated Divorced

Age _____ Occupation _____ Ins. Carrier _____

Please Circle the Appropriate Answer.

- 1 Do you need glasses to read? Yes No
- 2 Do you need glasses to see things at a distance? Yes No
- 3 Has your eyesight often blacked out completely? Yes No
- 4 Do your eyes continually blink or water? Yes No
- 5 Do you often have bad pains in your eyes? Yes No
- 6 Are your eyes often red or inflamed? Yes No
- 7 Are you hard of hearing? Yes No
- 8 Have you ever had a fluid leaking from your ear? Yes No
- 9 Do you have constant noises in your ears? Yes No
- 10 Do you have to clear your throat constantly? Yes No
- 11 Do you often feel a choking lump in your throat? Yes No
- 12 Are you often troubled with bad spells of sneezing? Yes No
- 13 Is your nose continually stuffed up? Yes No
- 14 Do you suffer from a constantly running nose? Yes No
- 15 Have you at times had bad nose bleeds? Yes No
- 16 Do you often catch severe colds? Yes No
- 17 Do you frequently suffer from heavy chest colds? Yes No
- 18 When you catch a cold, do you always have to go to bed? Yes No
- 19 Do frequent colds keep you miserable all winter? Yes No
- 20 Do you get hay fever? Yes No
- 21 Do you suffer from asthma? Yes No
- 22 Are you troubled by constant coughing? Yes No
- 23 Have you ever coughed up blood? Yes No
- 24 Do you wake up drenched with sweat during the middle of the night? Yes No
- 25 Have you ever had a chronic chest condition? Yes No
- 26 Have you ever had T. B. (Tuberculosis)? Yes No
- 27 Did you ever live with anyone who had T. B.? Yes No

- 28 Has a doctor ever said your blood pressure was too high? Yes No
- 29 Has a doctor ever said your blood pressure was too low? Yes No
- 30 Do you have pains in the heart or chest? Yes No
- 31 Are you often bothered by thumping of the heart? Yes No
- 32 Does your heart often race like mad? Yes No
- 33 Do you often have difficulty in breathing? Yes No
- 34 Do you get out of breath before anyone else? Yes No
- 35 Do you sometimes get out of breath just sitting still? Yes No
- 36 Are your ankles often badly swollen? Yes No
- 37 Do cold hands or feet trouble you, even in hot weather? Yes No
- 38 Do you suffer from frequent cramps in your legs? Yes No
- 39 Has a doctor ever said you had heart trouble? Yes No
- 40 Does heart trouble run in your family? Yes No
- 41 Are your joints often painfully swollen? Yes No
- 42 Do your muscles and joints constantly feel stiff? Yes No
- 43 Do you usually have severe pains in the arms or legs? Yes No
- 44 Are you crippled with severe arthritis? Yes No
- 45 Does arthritis run in your family? Yes No
- 46 Do weak or painful feet make your life miserable? Yes No
- 47 Do pains in the back make it hard for you to keep up with your work? Yes No
- 48 Are you troubled with a serious bodily disability or deformity? Yes No
- 49 Do you suffer from frequent severe headaches? Yes No
- 50 Does pressure or pain in the head often make life miserable? Yes No
- 51 Are headaches common in your family? Yes No
- 52 Do you have hot or cold spells? Yes No
- 53 Do you often have spells of severe dizziness? Yes No
- 54 Do you frequently feel faint? Yes No
- 55 Have you fainted more than twice in your life? Yes No
- 56 Do you have constant numbness or tingling in any part of your body? Yes No
- 57 Was any part of your body ever paralyzed? Yes No
- 58 Were you ever knocked unconscious? Yes No
- 59 Have you at times had a twitching of the head, face or shoulders? Yes No
- 60 Did you ever have a seizure or convulsion (epilepsy)? Yes No
- 61 Has anyone in your family ever had seizures or convulsion (epilepsy)? Yes No
- 62 Do you bite your nails? Yes No
- 63 Are you troubled by stuttering or stammering? Yes No
- 64 Are you a sleep walker? Yes No



NEW PATIENT HEALTH ANALYSIS

65	Are you a bed wetter?	Yes	No
66	Were you a bed wetter between the ages of 8 to 14?	Yes	No
67	Do you have to get up every night and urinate?	Yes	No
68	During the day, do you usually have to urinate frequently?	Yes	No
69	Do you often have severe burning when you urinate?	Yes	No
70	Do you sometimes lose control of your bladder?	Yes	No
71	Has a doctor ever said you had kidney or bladder disease?	Yes	No
72	Are you often exhausted or fatigued?	Yes	No
73	Does working tire you out completely?	Yes	No
74	Do you usually get up tired or exhausted in the morning?	Yes	No
75	Does every little effort wear you out?	Yes	No
78	Are you constantly too tired and exhausted to even eat?	Yes	No
79	Do you suffer from severe nervous exhaustion?	Yes	No
80	Does nervous exhaustion run in your family?	Yes	No
81	Are you frequently ill?	Yes	No
82	Are you frequently confined to bed by illness?	Yes	No
83	Are you always in poor health?	Yes	No
84	Are you considered a sickly person?	Yes	No
85	Do you come from a sickly family?	Yes	No
86	Do severe pains and aches make it impossible for you to do your work? ..	Yes	No
87	Do you wear yourself out worrying about work?	Yes	No
88	Are you always ill and unhappy?	Yes	No
89	Are you constantly made miserable by poor health?	Yes	No

Hours
by
appointment

ERIK D. BLISS, D.C., C.C.S.P.
7687 BEECHMONT AVENUE
CINCINNATI, OH 45255
(513) 232-9040
WWW.HEALTHYCHIRO.NET
WWW.BLISSCHIRO.COM