DR. JAY RAPPAZZO
INTEGRATED HEALTH SPECIALIST

Adult Health Questionnaire

Name_____ Date_____
Address_____City_____ Postal Code_____
H.Phone_____ W.Phone_____ Date of Birth_____
Occupation_____ Number of children and Ages_____
Referred by_____
Have you seen a chiropractor before? When? _____

About Your Health

You were born to be healthy! Unfortunately your health, your Innate Intelligence, can be interfered with. As Deepak Chopra M.D., has discovered, "All disease results from the disruption of the flow of intelligence." Chiropractic removes this interference when it happens in the spine (vertebral subluxation) so you can express your natural health potential throughout life?

1a. Is this a wellness check-up or do you have a specific health concern?

_____

b. What is your major complaint? Please describe?

_____

_____

_____

c. Is the condition interfering with work?____ sleep?____ hobbies?__

d. Have you consulted anyone else for this condition?

_____

e. Have you tried anything to get rid of this problem?

_____

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f. Other symptoms you have experienced in the last 6 months: (please circle)

Headaches	Pins & needles leg	Loss of smell
Neck pain	Pins & needles arm	Loss of taste
Sleeping problems	Numbness in toes	Diarrhea
Back pain	Shortness of breath	Feet cold
Nervousness	Fatigue	Hands cold
Tension	Depression	Stomach upset
Irritability	Constipation	Dizziness
Chest pain	Cold sweats	Ears ring
Loss of memory	Fever	
Loss of balance	Fainting	

2. **Birth Process** (Please fill out to the best of your knowledge)

Was your delivery long? _____
Was your delivery difficult? _____
Forceps? _____
Ceasarean? _____
Breach/Cephalic? _____
Home birth? _____
Hospital birth? _____
Mother given drugs during delivery? _____
Was labor induced? _____

3. **Growth & Development** (Please fill out to the best of your knowledge)

Were you breast fed? _____
Childhood sickness? _____
Accidents? _____
Surgery? _____
Drugs? _____
Any falls? _____
Did you have other traumas? What? When? _____
_____

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4. **Current Health Habits**

Did/do you smoke? _____
Did/do you drink any alcohol? _____
Diet (do you eat healthy foods)? _____
Have you been involved in any car accidents? When? _____
_____
Have you had surgery or organs removed or replaced?
_____
Drugs? (prescriptive or non-prescriptive) _____
Teeth problems? _____
Eye problems? _____
Hearing problems? _____
Exercise regular? _____
Did/do you have occupational stress? _____
Physical stress? _____
Mental stress? _____
Hobbies/Sports injuries? _____
Sleeping posture? _____

About Your Care

Chiropractic provides three types of care. The first is **Initial Intensive Care**, which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. Then begins **Reconstructive Care** which corrects the years of damage that occurred to your spine. **Wellness Care** is continued care to keep your body as healthy as possible. This will all be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.

Examination Fees

Consultation	--------Complimentary---------
Examination	$75.00
X-rays(if applicable)	$90.00

Patient Signature_____

Date _____

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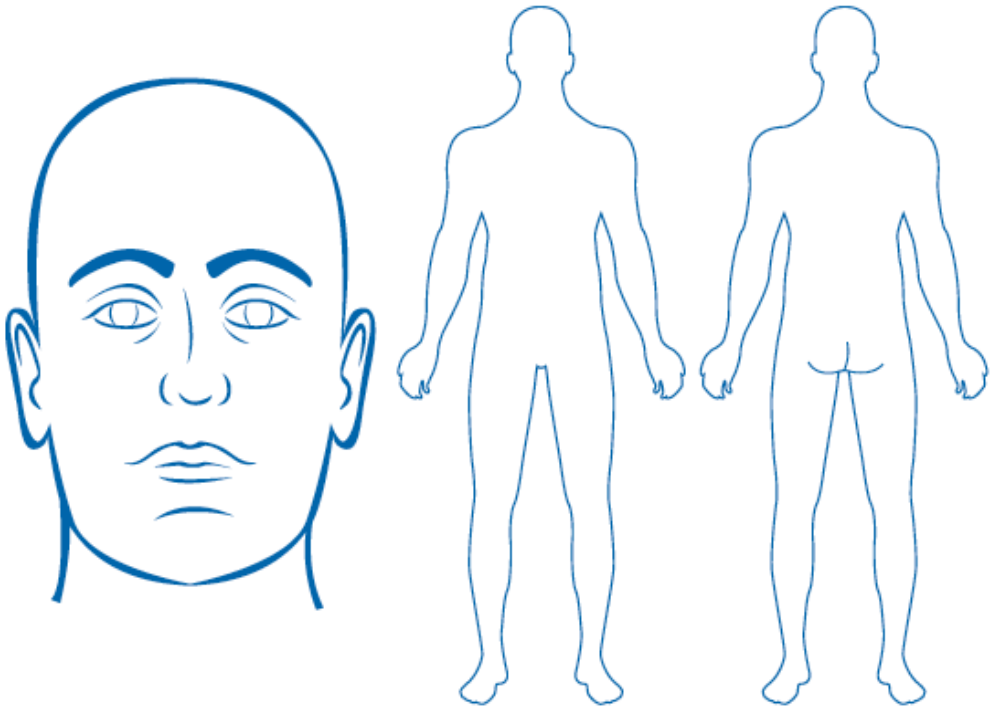
Additional Information

Please indicate where you are feeling discomfort. Provide as much detail as possible.



Symbols:

Numbness ====== Buring xxxxxxx Dull & Aching ^^^^^^^^

Pins and Needles 000000 Stabbing & Sharp ######

Stiff & Tight 222222

Additional Comments: