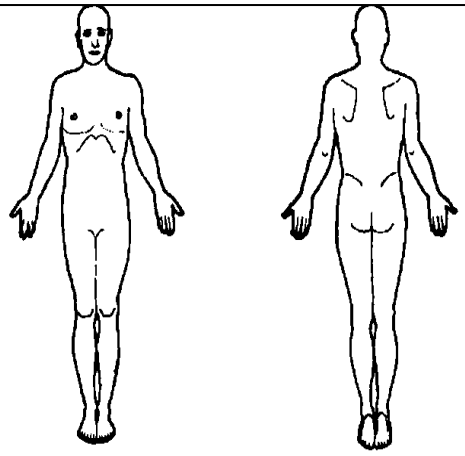
HEALTH HISTORY QUESTIONNAIRE

Name:_____

Have you ever been diagnosed or told you have any of the following?
Please circle the correct response.

1.	High blood pressure.....	Yes	No
2.	Hardening of the arteries (arteriosclerosis).....	Yes	No
3.	Diabetes.....	Yes	No
4.	Tuberculosis.....	Yes	No
5.	Cancer, Where?	Yes	No
6.	Heart or blood diseases.....	Yes	No
7.	Bone spurs on the neck bones (cervical sprain).....	Yes	No
8.	Whiplash injury (flexion-extension injury, cervical sprain).....	Yes	No
9.	Have you or any of your relatives ever suffered a stroke?	Yes	No
10.	Were you ever a smoker? From_____ To_____	Yes	No
11.	Do you take any medication on a regular basis?.....	Yes	No
12.	Visual disturbances (blurring, loss, double)	Yes	No
13.	Hearing disturbances (loss, ringing, other noise).....	Yes	No
14.	Slurred speech or other speech problems.....	Yes	No
15.	Difficulty swallowing.....	Yes	No
16.	Dizziness.....	Yes	No
17.	Loss of consciousness, even momentary blackouts.....	Yes	No
18.	Numbness, loss of sensation, strength or weakness in the face, fingers hands, arms, legs or any other parts of the body…..	Yes	No
19.	Sudden collapse without loss of consciousness.....	Yes	No

Indicate the location of your pain by shading in the appropriate area



Indicate the severity of the pain by circling a number.

| 0 1 2 3 4 5 6 7 8 9 10 |

No Pain Extreme Pain