Comparative Examination Questionnaire

PATIENT NAME: _____ *DATE:* _____

1. **What are your MAIN SYMPTOMS NOW (if any) ?** _____
   What relieves: _____ What aggravates: _____
   b. **Do your symptoms interfere with ___ work ___ family ___ hobbies ___ social life.**

2a. **What were your original complaints / symptoms ?** _____
   b. **Have these: 0** improved **0** same **0** worsened ? **Percentage of change:** _____

3. **Any recent falls /accidents ?** _____
   Exercise ? YES__ NO__ What Kind? _____ **How Often?** _____
4a. **Are you using any medication(s)?** If yes, names please: _____ Name of M.D.: _____
   b. **Do you take any supplements / vitamins ?** If yes, please list _____

5a. **What type of bed do you sleep on ?** ___Regular ___Waterbed ___Other **Pillow Type ?** _____
   b. **What position are you sleeping in most of the time ? ____ back ____ side ____ stomach ?**
   c. **Any other therapy being done ? ___ Physio ___ Massage therapy ___ Acupuncture ___ Other.**
   d. **Blood Type? A ___ B ___ AB ___ O ___**

6. **Are you currently experiencing any of the following ?**

0 LOW BACK PROBLEMS
0 PAIN BETWEEN SHOULDERS
0 NECK PROBLEMS
0 ARM PROBLEMS
0 LEG PROBLEMS
0 SWOLLEN / STIFF JOINTS
0 SORE MUSCLES
0 WEAK MUSCLES
0 BROKEN BONES

0 NUMBNESS
0 LOSS OF FEELING
0 PARALYSIS
0 DIZZINESS
0 FAINTING
0 HEADACHE
0 FORGETFULNESS
0 CONFUSION
0 DEPRESSION
0 CONVULSIONS

0 BLADDER TROUBLE
0 EXCESSIVE URINE
0 PAINFUL URINATION
0 DISCOLOURED URINE
0 SLUGGISH BOWELS

0 POOR APPETITE
0 EXCESSIVE HUNGER
0 DIFFICULT CHEWING
0 DIFFICULT SWALLOWING
0 EXCESSIVE THIRST
0 NAUSEA
0 VOMITING
0 ABDOMINAL PAIN
0 DIARRHEA
0 CONSTIPATION
0 BLACK STOOL
0 HEMORRHOIDS
0 LIVER TROUBLE
0 GALL BLADDER TROUBLE
0 WEIGHT TROUBLE

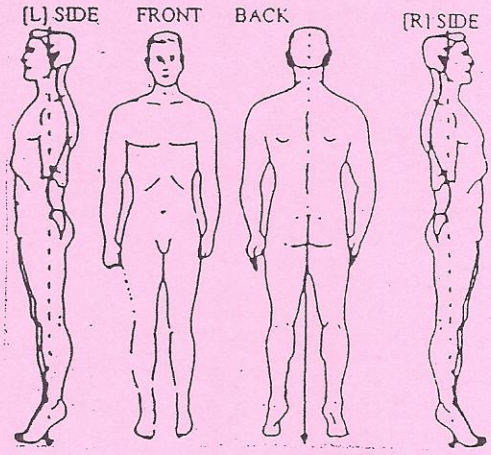
0 CHEST PAIN
0 PAIN OVER HEART
0 DIFFICULT BREATHING
0 PERSISTENT COUGH
0 COUGHING PHLEGM
0 RAPID HEART BEAT
0 BLOOD PRESSURE PROBLEMS
0 HEART PROBLEMS
0 LUNG PROBLEMS
0 HIATAL HERNIA

0 EYE STRAIN
0 EYE INFLAMMATION
0 VISION PROBLEMS
0 EAR PAIN
0 EAR NOISES
0 HEARING LOSS
0 EAR DISCHARGE
0 NOSE PAIN
0 NOSE BLEEDING
0 NOSE DISCHARGE
0 NOSE BREATHING
0 SORE GUMS
0 SORE MOUTH / JAW
0 DENTAL PROBLEMS
0 HOARSENESS
0 DIFFICULT SPEECH

0 VAGINAL DISCHARGE
0 VAGINAL BLEEDING
0 VAGINAL PAIN
0 BREAST PAIN
0 LUMPS ON BREAST

0 LOW ENERGY LEVEL
0 IRRITABILITY
0 MOOD SWINGS
0 BRAIN "FOG"
0 MENTAL STRESS

Place an X where you still have a symptom.



7. **Is there anything else the Doctor needs to know?** _____

Dr. Dougley would like to know if the "teacher" has educated the student. Please answer in your own words:

1. **What is a subluxation ?** _____
2. **What would happen if your subluxations were not corrected ?** _____
3. **What is HEALTH ?** _____

Ladies Only

8. **Any chance of you being pregnant ? 0 Yes 0 No 0 Maybe Date of last period** _____

Thank you for helping us serve you better.
Dr. Dougley and Staff

Signature _____ **Date** _____

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