St. George Wellness Centre

Last X-rays: _____

Progress/ Comparative Examination Questionnaire

Patient Name: _____ Date: _____

1a .What are your MAIN SYMPTOMS NOW (if any)? _____

b. What relieves: _____ What aggravates: _____

c. Do your symptoms interfere with ___ work ___ family ___hobbies ___ social life

2a. What were your original complaints/symptoms? _____

b. Have these: __ improved? __ same? __worsened? **Percentage of change:** _____

3. Any recent falls/accidents? _____ Exercise: _____

4a . Are you using any medication(s)? If yes, please name: _____Name of M.D._____

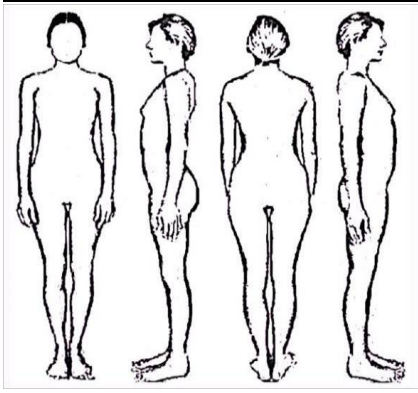
b. Do you take any supplements or vitamins? If yes, please list: _____

5a. What type of bed do you sleep on? ___ regular ___ waterbed ___ other ___ Type of pillow: _____

b. What position are you sleeping in most of the time? ___ back ___ side ___ stomach

c. Any other therapy being done? ___ Physio ___ Massage ___ Acupuncture ___ Osteopathy ___ Other

PLEASE MARK AN "X" WHERE YOU STILL HAVE A SYMPTOM:



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

- __ Low back problems
- __Pain B/W shoulders
- __ Neck problems
- __ Arm problems
- __Leg problems
- __Swollen joints
- __Painful joints
- __Stiff joints
- __ Sore muscles
- __ Weak muscles
- __Walking problems
- __ Ruptures
- __ Broken bones
- __
- __Loss of feeling
- __Paralysis
- __Dizziness
- __Fainting
- __Headaches
- __Muscle jerking
- __Convulsions
- __Forgetfulness
- __Confusion
- __Depression
- __Bladder trouble
- __Excessive urine
- __Painful urination
- __Scanty urine
- __Discoloured urine

- __Poor appetite
- __ Excessive hunger
- __ Difficulty swallowing
- __ Difficulty chewing
- __Excessive thirst
- __ Nausea
- __ Vomiting food
- __ Vomiting blood
- __ Abdominal pain
- __ Diarrhea
- __Constipation
- __ Black stool
- __ Bloody stool
- __Hemorrhoids
- __Liver trouble
- __Gall bladder problems
- __Weight trouble
- __Chest pain
- __Pain over heart
- __Difficulty breathing
- __Persistent cough
- __Coughing plegm
- __Rapid Heartbeat
- __Blood pressure problems
- __Heart problems
- __Lung problems
- __Varicose veins

- __ Eye strain
- __ Eye inflammation
- __Vision problems (spots, blurring)
- __ Ear pain
- __ Ear noises
- __ Hearing loss
- __ Ear discharge
- __ Difficulty breathing through nose
- __ Sore gums
- __Dental problems
- __ Sore mouth
- __ Hoarseness
- __ Difficult speech
- __Vaginal discharge
- __Vaginal bleeding
- __Vaginal Pain
- __Breast lumps
- __Low energy level
- __Irritability
- __Loss of sleep
- __Mood swings
- __Mental Stress
- __Disorientation
- __Burning sensations
- __Sharp, shooting pain
- __Brain "fog"

Is there anything else the Doctor needs to know?

_____

Dr. Sommer 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 – Any chance of you being pregnant? __Yes__No__Maybe Date of last period: _____

Thank you for helping us serve you better.

Signature:_____ Date: _____