HEALTH HISTORY QUESTIONNAIRE

DATE: _____

HOW DID YOU HEAR ABOUT US? (FRIEND, DOCTOR, INTERNET, WALK-IN, ETC.): _____

WHAT IS YOUR PRIMARY CONCERN/PROBLEM-DIAGNOSIS/REASON FOR VISIT? _____
_____

NAME: _____ PREFERRED NICKNAME: _____

PHONE: _____ DATE OF BIRTH: _____ AGE: _____

PHYSICIAN/REFERRING: _____

EMPLOYER: _____ CONTACT #:_____

ARE YOU IN NEED OF TREATMENT DUE TO:

ACCIDENT/AUTO: _____ WORK COMP RELATED: _____ LITIGATION PENDING: _____

LAWYER (IF APPLICABLE) : _____ CONTACT PHONE: _____

MEDICAL HEALTH HISTORY

PLEASE INDICATE CURRENT/PAST HISTORY OF THE FOLLOWING, STATUS AS OF TODAY:

CANCER/ONSET DATE: _____ TYPE/STAGE: _____ CURRENTLY IN TREATMENT (YES OR NO): __

HEART DISEASE/TYPE: _____ SURGERY/DATE? : _____ PACEMAKER? :_____

ORTHOPEDIC ISSUES/DATE OF ONSET:

ARTHRITIS: (YES OR NO/DESCRIBE): _____

OSTEOPOROSIS/AREA: _____

JOINT REPLACEMENT/S: _____

SPINE CONDITIONS (BACK, NECK, DIAGNOSED CONDITIONS, ETC.): _____

PROCEDURES/SURGERIES/INTERVENTIONS-SHOTS, TREATMENTS): _____

MEDICATIONS
LIST/ALLERGIES/REACTIONS:_____
_____

IMMUNE DISEASE: _____

DIABETES: TYPE I/II: _____ INSULIN-DEPENDENT? : _____

STROKE (TYPE/DATE OF ONSET/AFFECTED AREA): _____

HIGH BLOOD PRESSURE: _____ ON MEDS? : _____

LUNG/BREATHING PROBLEMS: _____ PLEASE SPECIFY RESULTS/CONCERNS: _____

NEUROLOGICAL ISSUES (MS, PARKINSONS, NEUROPATHY, PAIN): _____

HEARING OR VISUAL DIFFICULTIES (YES/NO/EXPLAIN): _____

STOMACH OR BOWEL CONDITIONS (YES/NO/EXPLAIN): _____

ANXIETY/DEPRESSION/PSYCHOLOGICAL CONCERNS: _____

HISTORY OF EXERCISE/ACTIVITY/HOBBIES:
_____
_____
_____

ANY OTHER CONDITIONS OR CONSIDERATIONS?: _____

_____

CURRENT LEVEL OF DAILY ACTIVITIES AND FUNCTION

ARE YOU EXPERIENCING DIFFICULTY WITH? :

EXERCISE:_____

SLEEPING:_____

SITTING:_____

STANDING:_____

TRANSITIONS/SIT TO STAND, OUT OF BED/CAR,ETC.:_____

DRESSING/GROOMING:_____

WALKING:_____

LIFTING:_____

SOCIAL LIFE/RECREATION ACTIVITIES:_____

TRAVEL:_____

OTHER; PLEASE LIST:

_____

_____

_____

PAIN

LOCATION: IDENTIFY IN DIAGRAM

HOW OFTEN DO YOU FEEL PAIN? (CIRCLE APPICABLE)

NONE INTERMITTENT AT NIGHT

CONSTANT WITH MOVEMENT

HOW WOULD YOU DESCRIBE YOUR PAIN?

_____

RATE PAIN (0=NONE, 10=WORST

_____