



## HEALTH QUESTIONNAIRE

**PATIENT NAME:** \_\_\_\_\_

**PATIENT DATE OF BIRTH:** \_\_\_\_\_ **TODAY'S DATE:** \_\_\_\_\_

Your answers to the following questions will help us to understand your medical history and concerns. Please fill out as much of this questionnaire as possible. If you cannot answer some of the questions or feel uncomfortable answering them, leave them blank. Thank you for your help.

**Reason for your visit today?** \_\_\_\_\_

**How long have you had this condition?** \_\_\_\_\_

**Have you received Physical Therapy or Occupational Therapy during this calendar year?**

Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes, please list: \_\_\_\_\_

**Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **Shoe Size** \_\_\_\_\_ **Dominant Hand: Right or Left (circle one)**

### MEDICAL HISTORY

Please list any **medication allergies or reactions:**

\_\_\_\_\_  
\_\_\_\_\_

**Please check to indicate if you have ever had the following conditions:**

<input type="checkbox"/> Anemia	<input type="checkbox"/> Fatigue / Weakness	<input type="checkbox"/> Latex Allergy	<input type="checkbox"/> Surgical Implants
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Headaches	<input type="checkbox"/> Metal Implants	<input type="checkbox"/> Swelling in Ankles
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Head Injury / Concussion	<input type="checkbox"/> Numbness / Tingling	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease / Attack	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Vascular Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Other (please list)
<input type="checkbox"/> Depression	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures / Epilepsy	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV / AIDS	<input type="checkbox"/> Shortness of Breath	
<input type="checkbox"/> Dizziness/Light-headedness	<input type="checkbox"/> Hypersensitivity to Heat /Cold	<input type="checkbox"/> Stroke	

**If you have marked any conditions above, please explain:** \_\_\_\_\_

\_\_\_\_\_

**More questions on reverse side**

Please list any surgeries or hospital stays you have had and their approximate date/year:

Type of surgery / reason for hospitalization/Year

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list **all** medications, including vitamins, herbal or natural supplements and prescription medications, which you are currently taking. Please note the dosage if possible.

*If you have a current list, we can make a copy for our records.*

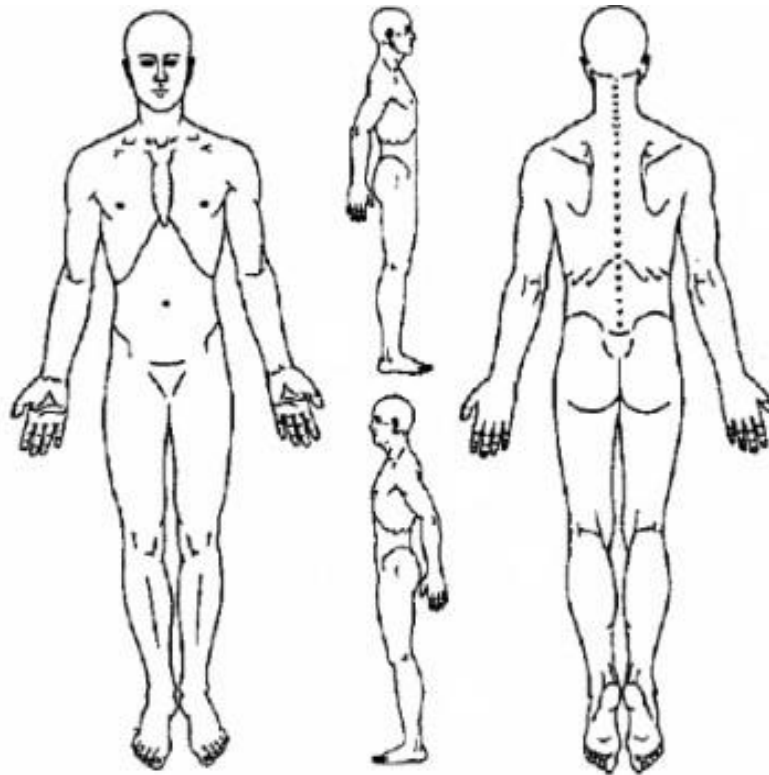
Medication Name

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**INSTRUCTIONS:** Please use the diagram below to indicate your current symptoms. Use the key to indicate the type of symptoms.

Pins and Needles = 000000  
Burning = xxxxxxxx

Stabbing = /////  
Deep Ache = zzzzzz



Please rate your current level of pain on the following scale (circle one):

0 (no pain)    1    2    3    4    5    6    7    8    9    10 (worst imaginable pain)