Health History Questionnaire

Name: _____ **Date:** _____

Health problems for which you are seeking treatment and date of onset:
1. _____
2. _____
3. _____
4. _____

Is this the result of an injury? YES/NO Auto _____ Work _____ Domestic Violence/Abuse _____

Date of injury? _____

Were x-rays, an MRI, CT scan, or Bone Density Scan done (specify when and what body part)?
_____
_____

Please list any surgeries or hospitalizations that have occurred (please specify dates):
1. _____ **2.** _____
3. _____ **4.** _____
5. _____ **6.** _____

Lifestyle/Social History:
Tobacco: YES/NO **Alcohol:** YES/NO **Illicit Drug Use:** YES/NO **Do you live alone:** YES/NO
Relationship Status: Single _____ Married _____ Significant Other _____
Children: YES/NO **If so how many?** _____ **Occupation:** _____
Do you use: Cane_____ Crutches_____ Walker_____ Wheelchair/Scooter_____
Dental night guard_____Braces/splints_____Orthotics_____Adapted car _____
Exercise: Days per wk_____ Length of workouts_____ Type of activity_____
Sleep Habits: Hours per night _____Quality _____Do you wake up feeling rested? _____
Stress Level _____Do **you engage in mind/body activities?** _____

Past Medical History: (circle all that apply)

Headaches	High/Low Blood Pressure	Gallstones	Vertigo/Dizziness
Migraines	Heart Disease	Skin Disease	Thyroid Disease
Stroke	Irregular Heartbeat	Kidney Disease	Anemia
Seizure Disorder	Heart Murmur	Kidney Stones	Pain
Glaucoma	Blood Clots/Phlebitis	Diabetes	Osteoporosis
Cataracts	High Cholesterol	Psychological/emotional issues	Fibromyalgia
Jaw Clicks or Locks	Angina/chest pain	Shortness of Breath	Stomach Ulcers
Ringing in the Ears	Weight Loss/Gain	Difficulty Breathing	Loss of Balance
Menopause	Cancer	Nausea	Hepatitis
Difficulty Swallowing	Fainting	Abdominal Pain	Emphysema
Blurred/Poor Vision	Change in Appetite	Bladder Problems	Pneumonia
Fevers	Neurological Disorder	Gout	Tremors
Chills	Multiple Sclerosis	Rheumatoid Arthritis	Osteoarthritis
Fatigue	Raynaud's	Muscle Fatigue/weakness	Poor memory
Asthma	Localized Weakness	Areas of Numbness	Liver Disease
Tuberculosis	Bleed/Bruise Easily	Lack of Coordination	

Other Health Problems: _____

Have you ever been treated for this injury before? YES/NO
If so, what was your treatment? _____
_____
Was it helpful? _____
_____
What things make your condition better? _____
What things make your condition worse? _____
Is your condition interfering with any activities of daily living? _____
What are your long-term goals for your treatment? _____

Indicate the intensity of your **pain at rest**:
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Indicate the intensity of your **pain with movement:** (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Using the following letters, mark on the diagram below where you feel these senstations on your body. A = Aching, N = Numbness, T = Tingling, B = Burning, S = Stabbing, ST = Stiffness, P = Pain