



**HEALTH QUESTIONNAIRE**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Email: \_\_\_\_\_

When did this episode begin? \_\_\_\_\_ (days, weeks, months, years)

What is bothering you? \_\_\_\_\_ When did it start? \_\_\_\_\_

Has this condition existed in the past? \_\_\_\_\_

Other HealthCare Provider Name you have tried: \_\_\_\_\_

- Yes  No  Yes, but has been dormant
- Comes & goes  Symptoms ongoing

**How frequent do your symptoms occur?**

- Infrequent  Occasional
- Frequent  Constant

**How are your daily activities affected?**

- Doesn't affect  Somewhat affects
- Seriously affects  Prevents activities

**Check the quality of your symptoms**

(Check all that apply):

- dull  sharp  aching
- burning  numbing  tingling
- spasm  stinging  shooting
- stiff  pounding  constricting

**Is this condition getting progressively worse?**

- Yes  No  Constant  Comes & goes

**What relieves your pain?**

- AM  PM  standing  sitting
- heat  ice  stretching  exercise
- bed rest  nothing  other \_\_\_\_\_

**What aggravates your pain?**

- AM  PM  standing  reaching
- sitting  stairs  sneezing  coughing
- lifting  bending  neck movement
- other \_\_\_\_\_

**Does your pain/symptoms radiate to your:**

- head  face  shoulders  arms
- hands  fingers  buttocks  hip
- rear thigh  front thigh  calf  shin
- ankle  foot  toes

**On a scale of 0-10 (10 = the worst) how bad does it get when it's at its worst?** \_\_\_\_\_

**Is this condition interfering with your:**

- work  sleep  daily routine
- family life  hobbies  sexual function
- social life  other \_\_\_\_\_

**How long has it been since you felt good?**

- weeks  months  years  other \_\_\_\_\_

**Sleep:**

- Do you have trouble falling asleep?  Yes  No
- Do you awaken in middle of the night?  Yes  No

- Family MD  Neurologist  Physical therapist
- Massage  Gynecologist  Orthopedic surgeon
- Counselor  Proctologist  Gastroenterologist
- Psychiatrist  Psychologist  Ear, nose & throat
- Hypnotist  Acupuncturist  Endocrinologist
- Allergist  Heart specialist  Pulmonary specialist
- Internist  Chiropractor  Rheumatologist
- Nutritionist  Kidney specialist  Pain specialist/clinic
- Other \_\_\_\_\_

**Check off any Tests you have received:**

- X-Rays  MRI  CAT scan
- EKG  Allergy test  Nerve conduction test
- EMG  Bone scan  Bone density test
- Myelogram  Ultrasound  Other \_\_\_\_\_

**Check off any Treatments you have tried:**

- OTC drugs  Ice  Prescription drugs
- Massage  Cortisone shots  Electrical stimulation
- Heat  Ultrasound  Physical therapy
- Ointments  Surgery  Accupuncture
- Traction  Manipulation  Other \_\_\_\_\_

**Work History:**

Do your present complaints affect the number of hours you work per day?  Yes  No

Are you working beyond your physical limitations because you **have** to work?  Yes  No

Job involves:  Lifting  Bending  Stooping  
 Twisting  Turning  Carrying  Walking  
 Sitting  Other \_\_\_\_\_

Has this caused you to miss work?  Yes  No  
If so, how much? \_\_\_\_\_ Last day worked? \_\_\_\_\_

If **RETIRED**, what occupation did you retire from?  
\_\_\_\_\_

If **DISABLED**, What is your disability and how long have you been disabled?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What was your last employed function?  
\_\_\_\_\_

Highest level of formal education completed:  
\_\_\_\_\_

**Check any MEDICATIONS you are taking, including Over The Counter (OTC) & Prescription (Rx):**

(check all that apply)	OTC	Rx
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Relaxants	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Steroids	<input type="checkbox"/>	<input type="checkbox"/>
Sinus/Allergy	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>

(check all that apply)	OTC	Rx
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Water Pills	<input type="checkbox"/>	<input type="checkbox"/>
Heart/Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>

(check all that apply)	OTC	Rx
Bowels/Laxative	<input type="checkbox"/>	<input type="checkbox"/>
Hormones	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Birth Control		<input type="checkbox"/>
Heartburn/Stomach	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>
NOT TAKING Medications	<input type="checkbox"/>	<input type="checkbox"/>

**Do you have difficulties with any of the following ACTIVITIES? (check all that apply)**

- |   |  |   |   |  |  |
|---|--|---|---|--|--|
| <input type="checkbox"/> Bathing          | <input type="checkbox"/> Drying Hair     | <input type="checkbox"/> Brushing Teeth   | <input type="checkbox"/> Put on shoes   | <input type="checkbox"/> Preparing meals   | <input type="checkbox"/> Put Trash out   |
| <input type="checkbox"/> Showering        | <input type="checkbox"/> Combing Hair    | <input type="checkbox"/> Making Bed       | <input type="checkbox"/> Tying shoes    | <input type="checkbox"/> Eating            | <input type="checkbox"/> Laundry         |
| <input type="checkbox"/> Washing Hair     | <input type="checkbox"/> Washing Face    | <input type="checkbox"/> Putting on shirt | <input type="checkbox"/> Put on pants   | <input type="checkbox"/> Washing dishes    | <input type="checkbox"/> Going to toilet |
| <input type="checkbox"/> Standing         | <input type="checkbox"/> Walking         | <input type="checkbox"/> Kneeling         | <input type="checkbox"/> Bending back   | <input type="checkbox"/> Twisting left     | <input type="checkbox"/> Leaning left    |
| <input type="checkbox"/> Sitting          | <input type="checkbox"/> Stooping        | <input type="checkbox"/> Reaching         | <input type="checkbox"/> Bending left   | <input type="checkbox"/> Twisting right    | <input type="checkbox"/> Leaning right   |
| <input type="checkbox"/> Reclining        | <input type="checkbox"/> Squatting       | <input type="checkbox"/> Bending forward  | <input type="checkbox"/> Bending right  | <input type="checkbox"/> Leaning forward   | <input type="checkbox"/> Leaning back    |
| <input type="checkbox"/> Prolong Standing | <input type="checkbox"/> Prolong sitting | <input type="checkbox"/> Prolonged walk   | <input type="checkbox"/> Prolong kneel  | <input type="checkbox"/> Climbing inclines | <input type="checkbox"/> Driving car     |
| <input type="checkbox"/> Carry objects    | <input type="checkbox"/> Lift from floor | <input type="checkbox"/> Pushing          | <input type="checkbox"/> Exercise upper | <input type="checkbox"/> Climbing stairs   | <input type="checkbox"/> Using keyboard  |
| <input type="checkbox"/> Carry briefcase  | <input type="checkbox"/> Lift from table | <input type="checkbox"/> Pulling          | <input type="checkbox"/> Exercise lower | <input type="checkbox"/> Exercise arms     | <input type="checkbox"/> Exercise legs   |
| <input type="checkbox"/> Bowling          | <input type="checkbox"/> Jogging         | <input type="checkbox"/> Swimming         | <input type="checkbox"/> Ice Skating    | <input type="checkbox"/> Comp Sports       | <input type="checkbox"/> Dating          |
| <input type="checkbox"/> Golfing          | <input type="checkbox"/> Dancing         | <input type="checkbox"/> Skiing           | <input type="checkbox"/> Roller skating | <input type="checkbox"/> Hobbies           | <input type="checkbox"/> Dining out      |
| <input type="checkbox"/> Concentrating    | <input type="checkbox"/> Seeing          | <input type="checkbox"/> Hearing          | <input type="checkbox"/> Touching       | <input type="checkbox"/> Tasting           | <input type="checkbox"/> Smelling        |

**REVIEW OF SYSTEMS (check all that apply)**

**General**

- Chills
- Fainting
- Fever
- Forgetfulness
- Loss of Weight
- Nervousness
- Sweats

**Genito-Urinary**

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

**Eyes**

- Crossed eyes
- Double vision
- Vision - Flashes
- Vision - Halos
- Blurred vision

**Ears/Nose/Throat**

- Earache
- Ear Discharge
- Loss of hearing
- Nose bleeds
- Hoarseness
- Difficulty swallowing
- Persistent cough

**Respiratory**

- Chest Pain
- Cough
- Congestion
- Distress
- Sputum
- Shortness of breath

**Endocrine**

- Weight gain
- Weight loss
- Hoarseness
- Heat Intolerance
- Cold Intolerance
- Breast Changes
- Hair Changes
- Extreme Thirst

**Gastrointestinal**

- Appetite poor
- Bloating
- Bowel changes
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting no blood
- Vomiting with blood

**Cardiovascular**

- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

**Men only**

- Breast lumps
- Erection difficulties
- Lump in testicles
- Penis discharge
- Prostate Problem
- Other \_\_\_\_\_

**Women Only**

- Abnormal pap smear
- Bleeding between periods
- Breast lumps
- Miscarriage
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Vaginal Infections
- Date of last menstrual period \_\_\_\_\_
- Date of last pap smear \_\_\_\_\_
- Have you had a mammogram? \_\_\_\_\_
- Are you pregnant? \_\_\_\_\_
- Number of children \_\_\_\_\_
- Other \_\_\_\_\_

**Integumentary (skin)**

- Bruise easy
- Hives
- Change in moles
- Sores that won't heal
- Itching
- Unusual swelling
- Sores/ulcers
- Rash
- Scars

**Neurological**

- Seizures
- Vertigo
- Dizziness
- Hand Trembling
- Loss of Sensations
- Loss of facial expression
- Weak Grip
- Paralysis
- Difficulty of Speech
- Tingling
- Numbness
- Un-coordination

**Psychiatric**

- Hyperventilation
- Insecurity
- Trouble Sleeping
- Irritable
- Undecidedness
- Timid
- Hallucinations
- Loss of Memory
- Alcoholism
- Drug Addiction
- Drug Dependency
- Extreme Worry
- Sexual Problems
- Suicidal Thoughts

**Conditions**

- AIDS
- Alcoholism
- Anorexia
- Appendicitis
- Back pain at night
- Bleeding Disorders
- Breast Lumps
- Bronchitis
- Bulimia
- Cancer
- Cancer Bone Softening Disease

- Cataracts
- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Fracture
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes
- High Cholesterol
- HIV Positive
- Joint Instability
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Pneumonia
- Polio
- Psoriasis
- Psychiatric Care
- Reiter's Syndrome
- Rheumatoid Arthritis
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Suicide Attempt
- Surgery
- Thyroid Fever
- Ulcers
- Venereal Disease
- Other \_\_\_\_\_

CLIENT SIGNATURE: