HEALTH HISTORY QUESTIONNAIRE

To ensure you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand a question, your therapist will assist you. Thank you.

NAME _____ DATE _____

OCCUPATION _____ HOBBIES _____

Presently working? Yes_____ No _____ Full time _____ Part time _____ Unemployed _____ Student _____

PHYSICAL ACTIVITIES AT WORK _____

Are you currently receiving or seeking disability? Yes _____ No _____ For this condition _____ Other _____

DATE OF LAST PHYSICAL EXAMINATION (if known) _____ HEIGHT _____ WEIGHT _____

HOW IS YOUR GENERAL HEALTH? Excellent _____ Good _____ Average _____ Fair _____ Poor _____

EXERCISE LEVEL: Zero ____ 1-2 days/wk ____ 3-4 days/wk ____ 5+ days/wk ____ Consisting of _____

_____

STRESS LEVEL Low _____ Medium _____ High _____

ARE YOU CURRENTLY SEEING ANY OF THE FOLLOWING?

Medical Doctor	YES	NO	Psychiatrist/Psychologist	YES	NO
Osteopath	YES	NO	Physical Therapist	YES	NO
Dentist	YES	NO	Chiropractor	YES	NO
Naturopath	YES	NO	Other _____	YES	NO

IF YOU HAVE SEEN ANY OF THE ABOVE IN THE LAST 3 MONTHS, PLEASE DESCRIBE FOR WHAT REASON (illness, medical condition, physical, etc.) AND INDICATE IF IT WAS RELATED TO YOUR PRESENT SYMPTOMS.

_____

_____

_____

SINCE THE ONSET OF YOUR CURRENT SYMPTOMS HAVE YOU HAD:

Any difficulty with control of bowel or bladder function?	YES	NO	Fever/Chills	YES	NO
Any numbness in the genital or anal area?	YES	NO	Numbness	YES	NO
Any dizziness or fainting attacks?	YES	NO	Weakness	YES	NO
Unexplained weight change?	YES	NO	Night Pain/Sweats	YES	NO
Malaise (vague feeling of bodily discomfort)?	YES	NO	Problems with vision/hearing	YES	NO

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery/hospitalization:

DATE	INJURY	DATE	INJURY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please describe any injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

DATE	INJURY	DATE	INJURY
_____	_____	_____	_____
_____	_____	_____	_____

Please turn over and complete side 2

HAVE YOU, OR ANY MEMBER OF YOUR IMMEDIATE FAMILY (parents, brothers, sisters) EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS? Please check all that apply to you, and write in relationship of family member to you with any conditions that apply.

YOU	**FAMILY MEMBER**	
____	_____	Cancer (if yes, descibe what kind)_____
____	_____	Heart problems
____	_____	High Blood Pressure
____	_____	Asthma
____	_____	Emphysema/Bronchitis
____	_____	Chemical Dependency (Alcoholism)
____	_____	Thyroid Problems
____	_____	Diabetes
____	_____	Multiple Sclerosis
____	_____	Rheumatoid Arthritis
____	_____	Other Arthritic Conditions
____	_____	Depression
____	_____	Hepatitis
____	_____	Tuberculosis
____	_____	Stroke
____	_____	Kidney Disease
____	_____	Anemia
____	_____	Epilepsy/Seizures
____	_____	Allergies
____	_____	HIV/Acquired Immune Deficiency Syndrome
____	_____	Anorexia/Bulimia
____	_____	Other_____

WHICH OF THE FOLLOWING OVER-THE-COUNTER MEDICATIONS HAVE YOU TAKEN IN THE LAST WEEK?

____ Asprin	____ Laxitives	____ Antacid
____ Tylenol	____ Decongestants	____ Vitamins/mineral supplements
____ Advil/Motrin/Ibuprofen	____ Antihistamines	____ Corticosteroid

Other _____

PLEASE LIST ANY <u>PRESCRIPTION</u> MEDICATION YOU ARE CURRENTLY TAKING (including pills, injections, and/or skin patches):_____

_____

How much caffeinated coffee or caffeine containing beverages do you drink per day?_____
If one drink equals one beer or glass of wine, how much do you drink at an average sitting?_____
How many days a week do you drink alcohol? _____
How many packs of cigarettes do you smoke a day? _____