HEALTH QUESTIONNAIRE

Name: _____ Date: _____

Past Medical History

For each condition, please place an "X" in the appropriate column.

	Have now	Had in past, but not now		Have now	Had in past, but not now		Have now	Had in past, but not now
MAJOR PAST HISTORY								
Cancer			Diabetes			Heart attack		
Seizures			Pace maker			TIA/stroke		
Headaches/migraine			High blood pressure			Immune disorders		
Other/comments:								
GENERAL / ENDOCRINE								
Alcoholism			Anemia			Anxiety		
Depression			Thyroid disorders			Low blood sugar		
Other/comments:								
GASTROINTESTINAL								
Gall bladder problem			Blood/mucus in stool			Stomachache		
Colitis			Vomiting			Polyps/Diverticulosis		
Heartburn			Constipation			Poor appetite		
Nausea			Recent weight gain			Liver disease/hepatitis		
Diarrhea			Recent weight loss					
Other/comments:								
CARDIOVASCULAR								
Pain or unusual feelings in chest			Coronary arterial disorder			Varicose veins		
Palpitations			High cholesterol			Heart failure		
Swelling in ankles			Irregular heartbeat			Arterial aneurysm		
Shortness of breath			Low blood pressure			Heart murmur		
Other/comments:								
NERVOUS SYSTEM								
Fainting			Memory loss			Tremor of limbs		
Dis-coordination			Speech difficulty			Paralyzed limbs		
Dizziness/ lightheadedness			Other/comments:					
EYES, EARS, NOSE & THROAT								
Vision problems/ blurry /double vision			Ear noises/ringing in ears			Nose bleeds		
Sinus problems			Dental problems			Difficulty swallowing		
Ear problems			Other/comments:					
RESPIRATORY								
Coughing up blood			Difficulty breathing			Chronic obstructive pulmonary disease		
Chronic cough			Asthma					
Other/comments:								

HEALTH QUESTIONNAIRE

	Have now	Had in past, but not now		Have now	Had in past, but not now		Have now	Had in past, but not now
URINARY TRACT								
Blood in urine			Kidney stones			Puffy face/eyelids		
Painful urination			Bladder infection			Leg/foot edema		
Inability to control urination			Other/comments:					
WOMEN ONLY								
Hysterectomy			Menopausal symptoms			C-sections		
Irregular periods			Painful breasts			Genital tumors		
Lumps in breasts			Vaginal discharge			Excessive flow		
Premenstrual symptoms, e.g. cramps, headaches, mood changes			Other/comments:					
MEN ONLY								
Prostate problems			Need to urinate at night			Hernias		
Feeling of incomplete urination			Difficulty starting urination			Dripping after urination		
Blood in urine			Sexual dysfunction					
Other/comments:								
NEUROMUSCULOSKELETAL								
Headaches			Low back pain			Arthritis		
Neck pain			Upper extremity pain			Numbness / tingling		
Mid-back pain			Lower extremity pain					
Other/comments:								

Please list any:	**Date(s)**	**Comments**
Surgeries (including minor and cosmetic)		
Hospitalizations		
Pregnancies & births		
Significant traumas (concussions, auto accidents, falls, etc.)		
Allergies (drugs, foods, chemicals)		
Medications (prescription and over-the counter) taken within the past two months		
Vitamins, supplements, herbs taken within the past two months		

HEALTH QUESTIONNAIRE

Family Medical History

Have any immediate or secondary family ever been diagnosed with:			Family member(s) diagnosed:
Cancer	yes	no	
Diabetes	yes	no	
High Blood Pressure	yes	no	
Heart Disease	yes	no	
Stroke	yes	no	
Arthritis	yes	no	
Seizures	yes	no	

Lifestyle / Health Promotion

1. How many hours of sleep do you get per night on average?	0 1 2 3 4 5 6 7 8 9 10 11 12
2. How would you rate your sleep quality?	Excellent Good Average Fair Poor
3. Are you following a special diet (vegan, vegetarian, Weight Watchers, etc.)? If yes, briefly explain.	Yes No
4. How many meals do you usually eat per day?	0 1 2 3 4 5 6 more than 6
5. Do you usually snack in between meals?	No Yes
6. How often do you usually eat out each week?	0-3 4-6 7-10 10+
7. How many servings of fruits & vegetables do you usually eat per day?	0 1 2 3 4 5 6 more than 6
8. How many cups of water do you usually drink per day? (1 cup = 8 ounces)	0 1 2 3 4 5 6 7 8 9 10 11 12
9. How many days per week do you exercise on average?	0 1 2 3 4 5 6 7
10. Briefly describe your exercise program.	
11. Have you ever habitually smoked cigarettes?	Yes No
12. Do you presently smoke cigarettes?	Yes No
13. Do you drink alcohol?	Yes No
14. Do you use any recreational drugs?	Yes No
15. Describe any habits you feel are affecting your health.	
16. How would you rate your stress level?	Very High High Medium Low Very Low
17. What are your stressors?	
18. Do you feel sad a good deal of the time?	Yes No
19. How would you describe your health in general?	Excellent Good Fair Poor
20. Does your health prevent you from: a. Working b. Participating in social activities? c. Participating in hobbies? d. Being sexually active?	 Yes No Yes No Yes No Yes No

INITIAL PROBLEM RECORD

Name: DOB:

Date: Do you smoke? □ Yes □ No

Chief Complaint

What is your main complaint or problem?

How did this begin?

When did this begin?

Has this happened before? If yes, when?

What makes your problem better?

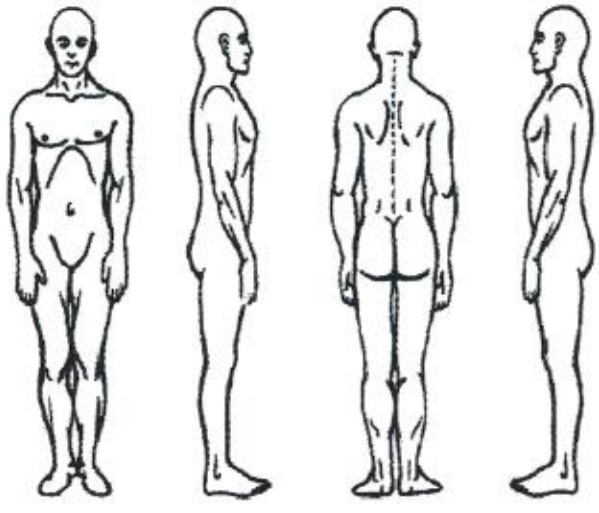
What makes your problem worse?

Since the problem began, it has: □ Improved □ Worsened □ Not changed

This problem bothers me: □ Occasionally (0 - 25% of the time) □ Intermittently (25 - 50% of the time)
□ Frequently (50 - 75% of the time) □ Constantly (75 - 100% of the time)

Do you have any other related or unrelated complaints you would like to address?

If applicable, please mark your areas of complaint on the diagrams below using the symbols to the right.



Aching
^^^

Numbness
+++

Pins and Needles
000

Burning
xxx

Stabbing or Sharp
///

Rate your main complaint today:

None 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

Rate your other complaint(s) today. If more than one complaint, label each rating.

None 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

INITIAL PROBLEM RECORD

Previous Testing

Please indicate previous tests you have had for this problem, when they were performed and the results.

Test	Date	Results
☐ X-ray		
☐ MRI		
☐ CT		
☐ Lab		
☐ Other		

Previous Treatment

Please indicate previous treatments you have had for this problem, when they were performed and the results:

Treatment	Results / Comments
Medication: ☐ Ibuprofen ☐ Naprosyn ☐ Prednisone ☐ Medrol dose pack ☐ Other (specify)	☐ Helped ☐ Worsened ☐ No effect ☐ Helped ☐ Worsened ☐ No effect ☐ Helped ☐ Worsened ☐ No effect ☐ Helped ☐ Worsened ☐ No effect ☐ Helped ☐ Worsened ☐ No effect
Injection: ☐ Steroid injection ☐ Other (specify)	☐ Helped ☐ Worsened ☐ No effect

Treatment	Results / Comments
☐ Surgery Date:	☐ Helped ☐ Worsened ☐ No effect
Conservative care: ☐ Acupuncture ☐ Chiropractic ☐ Physical Therapy ☐ Other	☐ Helped ☐ Worsened ☐ No effect ☐ Helped ☐ Worsened ☐ No effect ☐ Helped ☐ Worsened ☐ No effect

Current Work Status

Employer: Job title: Time at position:

Work status: ☐ Regular duty ☐ Modified duty ☐ Off work - Date began modification or off work:

Description of your normal job activities:

	Sitting	Standing	Walking	Driving	Lifting*
Total hours in a normal work day					
Max duration at one time at work					

* If lifting at work, what is the average weight? How many times do you lift per hour?

Daily Functions

List the four ACTIVITIES OF DAILY LIVING that are impeded by your problem that you would want restored:

1.
2.
3.
4.