Health History Questionnaire

Name: _______________________________ **Drug/Latex/Other Allergies**: ___________________

Do you have a Pacemaker? □Yes □No Do you smoke or use other tobacco products? □ Yes □ No

Yes No

□ □ Are you or could you be pregnant at this time or have you been pregnant in the past 6 months?
□ □ Do you ever feel unsafe in your home?
□ □ Has anyone ever hit you or tried to harm you in any way?
□ □ In the past month, have you had feelings of being down, depressed, or hopeless?
□ □ In the past month, have you had little interest or pleasure in doing things?

Have you EVER been diagnosed with any of the following? ***(check all that apply)***

□ Cancer. **Type?** ____________
□ Diabetes (**Type 1 or Type 2)**
□ Cardiovascular disease
□ Depression
□ Neurological conditions
□ Hepatitis **Type:** _________
□ HIV/AIDS
□ Drug/Alcohol Dependency
□ Kidney Disease
□ Thyroid Problems
□ Lung conditions
□ Liver Disease
□ Urinary Tract Infection
□ Incontinence
□ Stroke
□ **High** / **Low** Blood Pressure
□ Osteoarthritis
□ Rheumatoid Disease
□ Osteoporosis/ Osteopenia
□ Pelvic pain
□ STD/STI

Other (please include any serious injuries): ____

Have any of your immediate family been diagnosed with any of the following? (check all that apply)

□ Cancer □ Heart Problems □ Stroke □ High Blood Pressure

Surgical History: *Please list any surgeries or hospitalizations*

____

Medications: *Please list* ***ALL*** *medications you are taking, including pills, injections, and over-the-counter meds*

____
____

Please check any symptoms you have had RECENTLY:

□ Fatigue
□ Weight Loss/Gain
□ Numbness/Tingling
□ Dizziness
□ Nausea/Vomiting
□ Shortness of Breath
□ Chest Pain/Pressure
□ Falls
□ Heartburn/Indigestion
□ Fever/Chill/Night Sweats
□ Bowel/Bladder Changes
□ Change in hearing /vision

Using the 0 to 10 scale, with 0 being no pain, 10 being “worst pain imaginable”, answer the following:

The <u>worst</u> your pain has been during the past 24 hours: _______
Your <u>current</u> level of pain while completing this survey: _______
The <u>best</u> your pain has been during the past 24 hours: _______

What are your goals with therapy?

____