

HEALTH QUESTIONNAIRE

1. Name: _____ Date of Birth: _____ Height: _____ Current Weight: _____
2. Have you had physical, occupational or speech therapy this year? Yes No If yes, please provide date and location _____
3. Have you had home health services this year? Yes No If yes, please provide date and location _____

4. With whom do you live?

- Alone Spouse only Spouse and others Child (not spouse)
 Other Relative(s) Group Setting Personal Care Attendant Other

5. GENERAL HEALTH STATUS

a. Please rate your health:

- Excellent Good Fair Poor

b. Have you had any major life changes during the past year? (eg. New baby, job change, death of a family member)

- Yes No

c. Are you pregnant?

- Yes No Unsure

6. SOCIAL/HEALTH HABITS

Do you currently smoke tobacco? Yes No If yes, how many packs or cigarettes/cigars per day? _____

7. MEDICAL/SURGICAL HISTORY – Please check if you have ever had or are currently being treated for:

- Arthritis High Blood Pressure Depression Other _____
 Broken Bones/fractures Head Injury Heart Problems
 Stroke Osteoporosis Low Blood Sugar/Hypoglycemia
 Diabetes/high blood sugar Seizure/Epilepsy Cancer

8. Within the past year, have you had any of the following symptoms? (Check all that apply)

- Chest Pain Shortness of breath Other
 Hoarseness Pain at night
 Weakness in arms or legs Weight loss/gain
 Joint pain or swelling Nausea/vomiting

Have you ever had surgery? Yes No If yes, please describe, and include dates:

Month _____ Year _____
Month _____ Year _____

9. MEDICATIONS

a. Do you take any prescription medications? Yes No

If yes, please list: _____

b. Do you take any non-prescription medications? Yes No

If yes, please list: _____

10. OTHER CLINICAL TESTS – Within the past year, have you had any of the following tests? Please check and tests you have had in regard to your current complaints. (Check all that apply)

- Arthroscopy EKG (electrocardiogram) EMG (electromyogram) Stress Test (eg. Treadmill)
 Bone Scan MRI Echocardiogram Other
 CT Scan NCV (nerve conditioning velocity) X-Ray

I hereby certify that I have personally answered all of the questions on this form and that my answers are true and complete to the best of my knowledge and belief.

Date _____ Patient Signature _____