PERSONAL HEALTH QUESTIONNAIRE

NAME: (FIRST & LAST)____DATE: ____/____/____

INSTRUCTIONS: Please fill out this questionnaire as complete as possible. The more information we have the better we can design a more complete program to meet your needs. Your information will be fully protected and not shared with anyone outside of this facility unless you authorize us to do so. If you have any questions, please ask for assistance.

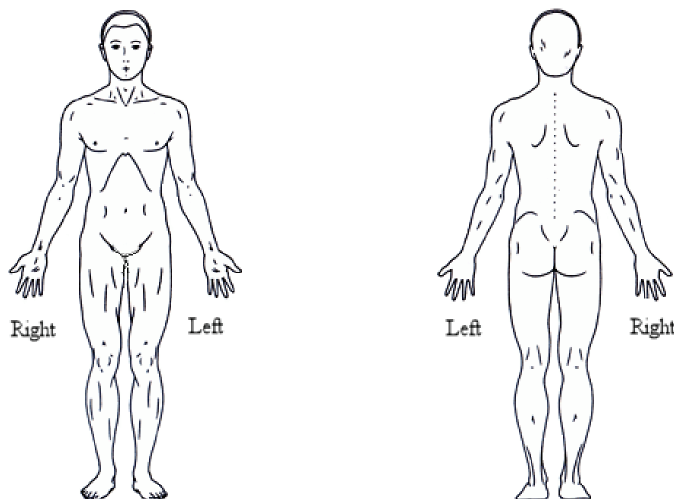
▪YOUR AGE: _______ ▪YOUR DATE OF BIRTH:____/____/____ ▪GENDER: M○ F○

▪YOUR OCCUPATION:_______________________________________

▪RATE IN TIME HOW YOU SPEND MOST OF YOUR DAY:
_____(HRS) SITTING _____(HRS) STANDING _____(HRS) MANUAL LABOR _____(HRS) LYING DOWN (SLEEP)
____(MIN.) EXERCISE
▪DATE OF YOUR LAST PHYSICAL EXAMINATION: ____/____/____
▪APPROXIMATE DATE OF YOUR LAST BLOOD EVALUATION: ____/____/____
▪APPROXIMATE DATE OF YOUR LAST XRAY OR MRI: ____/____/____
▪WHAT WERE THE RESULTS OF THE ABOVE TESTS?

▪DO YOU HAVE AN INJURY OR AREA OF PAIN? PLEASE DESCRIBE.

▪PLEASE DRAW ON THE BELOW BODY YOUR AREAS OF CONCERN.



▪If you have a chronic area of pain, please elaborate on the following?
WHERE?
WHEN DID IT START?
TREATMENT RECEIVED?
WHY DO YOU THINK IT HAS BEEN CHRONIC?

▪Do you have now or have you had in the past 3 years: (PLEASE PLACE A "X" IN APPROPRIATE AREA)

		CURRENT	PAST	NEVER	FAMILY HISTORY
Muscle/Joint/Bone	Neck				
(pain, numbness, weakness):	Shoulders				
	Arms				
	Hands				
	Back				
	Hips				
	Legs				
	Feet				
Cardiovascular:	Chest pain				
	High blood pressure				
	Irregular heart beat				
	Low blood pressure				
	Poor circulation				
	Rapid heat beat				
	Swelling of ankles				
	Varicose veins				
	Blood in urine				
Genito-Urinary:	Frequent urination				
	Lack of bladder control				
	Painful urination				
	Poor appetite				
	Excessive appetite				
Gastrointestinal:	Bowel changes				
	Constipation				
	Diarrhea				
	Excessive thirst				
	Excessive gas or bloating				
	Indigestion frequently				
	Hemorrhoids				
	Rectal bleeding				
	Nausea				
	Stomach pain				
	Vomiting				
	Blurred vision/double vision				
	Difficulty swallowing				
	Earache with or without discharge				
Ear, Nose, Throat:	Allergies/hay fever				
	Hoarseness				
	Loss of hearing				
	Nosebleeds				

		CURRENT	PAST	NEVER	FAMILY HISTORY
	persistent cough	_	_	_	_
	Ringing in the ears				
	Sinus problems				
	Vision-flashes or halos				
	Bruise easily				
	Hives				
	Excessive itching				
	Change in moles				
Skin:	Rash				
	Scars				
	Slow healing wound				
	Chills				
	Depression				
	Dizziness				
	Fainting				
	Fever				
General:	Forgetfulness				
	Headache				
	Loss of sleep				
	Anxiety				
	Nervousness				
	Sweats				
Men only:	Breast lump				
	Erectile difficulties				
	Lump in testicles				
	Penis discharge				
	Sore on penis				
Women only:	Abnormal pap smear				
	Bleeding between periods				
	Breast lump				
	Extreme menstrual pain				
	Hot flashes				
	Nipple discharge				
	Painful intercourse				
	Vaginal discharge				
	Other:				

- Date of last menstrual period: ____/____/____
- Date of last pap smear & exam:____/____/____
- Are you pregnant or think you may be pregnant?: ____YES ____NO
- Have you had any children?: ____YES ____NO

▪DO YOU HAVE OR HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?:
(PLEASE MAKE AN “X” TO ANY “YES” ANSWERS)

____AIDS
____ALCOHOLISM
____ANEMIA
____ANOREXIA
____APPENDICITIS
____ARTHRITIS
____ASTHMA
____BLEEDING DISORDERS
____BREAST LUMP
____BRONCHITIS
____BULIMIA
____CANCER
____CATARACTS

____CHEMICAL DEPENDENCY
____CHICKEN POX
____DIABETES
____EMPHYSEMA
____EPILEPSY
____GLAUCOMA
____GOITER
____GONORRHEA
____GOUT
____HEART DISEASE
____HEPATITIS
____HERNIA
____HERPES

____HIGH CHOLESTEROL
____HIV POSITIVE
____KIDNEY DISEASE
____LIVER DISEASE
____MEASLES
____MIGRAINES
____MISCARRIAGE
____MONONUCLEOSIS
____MULTIPLE SCLEROSIS
____MUMPS
____PACEMAKER
____PNEUMONIA
____POLIO

____PROSTATE PROBLEM
____PSYCHIATRIC CARE
____RHEUMATIC FEVER
____SCARLET FEVER
____STROKE
____SUICIDE ATTEMPT
____THYROID PROBLEMS
____TONSILITIS
____TUBERCULOSIS
____TYPHOID FEVER
____ULCERS
____VAGINAL INFECTION
____VENEREAL DISEASE

▪Do you have ANY medical conditions not included in the list above: (please describe and list):

▪Please list any medications or supplements that you take, how often you take them, what you take them for, and if any of them affect heart rate or cardiovascular health:

▪Have you had any surgeries or hosptilizations in your lifetime? If YES please list when and what for:

▪Who are your primary and secondary medical providers (family physician, OBGYN, internist, psychiatrist, counselor, nutritionist, Chiropractor, Osteopath, Acupuncturist, etc…)

	NAME	LOCATION	TYPE OF CARE
1)			
2)			
3)			
4)			

▪WHAT IS YOUR REASON FOR YOUR VISIT TO OUR FACILITY? PLEASE DESCRIBE.

▪Do you get regular sleep? What is an average night sleep?

▪What do you do now for stress relief or relaxation?

▪Do you have any learning disabilities or cognitive challenges? If yes, please explain.

▪WHAT IS YOUR *CURRENT* STRESS LEVEL: ____LOW ____MODERATE ____HIGH
▪WHAT IS YOUR *AVERAGE* STRESS LEVEL: ____LOW ____MODERATE ____HIGH

▪What type of shoes do you wear (on average)?:
Shoe type at work:
Shoe type while off work:
Shoe type while out socially:
Shoe type while exercising::

Functional Measurements:
▪Does your area of concern limit you from doing things? If yes, please explain.

▪Please check any of the following that you think will help your area of concern:
____manual therapy ____exercise ____strength ____flexibility

▪Do you drink caffeine? If YES in what form, how much, and how often?

▪Do you have an addiction to refined sugar, artificial sugar, or carbohydrates? ____YES ____NO

▪Do you smoke cigarettes or medical use marijuana?: ____YES ____NO If YES, which one and how often?____

▪Do you drink alcohol? ____YES____NO, if YES, please list the types of alcohol and how often you consume them:____

▪Do you do recreational drugs?: ____YES ____NO, if YES, how often:______________________________

▪Are you willing to make changes in your lifestyle to change your current fitness level? ____YES ____NO

I, ______________________________(your name), I agree to immediately tell my doctor/therapist(s) at this facility of any medical conditions , injuries, or pregnancy. I have read, understood, and completed this questionnaire as complete as I am willing to disclose. I understand that if I have not disclosed items on this questionnaire it may affect the quality of my program design and further hinder my health progress.

____
Your first and last name

____
Your signature date

____
Signature of parent or guardian if under age 18