Health Questionnaire

Name:_____ Date: _____

1. Please list all medical complaints in order of importance:

_____
_____
_____
_____
_____

2. Please list all prescription medications you are taking:

Name of Medication	Reason for Medication

3. List Vitamins and Supplements you are currently taking:

4. Please list all surgeries and the year they were performed:

5. Family History

	Age	Health Issues and/or cause of death
Mother:		
Father:		
Mother's Mother:		
Mother's Father:		
Father's Mother:		
Father's Father:		
Brothers:		
Sisters:		
Children:		

6. Please check the Conditions you have or have had:

( ) ADHD
( ) AIDS
( ) Allergic Rhinitis
( ) ALS
( ) Alzheimer's Disease
( ) Ankylosing Spondylitis
( ) Anorexia
( ) Anxiety
( ) Aortic Aneurysm
( ) Arterial Disease
( ) Asthma
( ) Atherosclerosis
( ) Autism
( ) Bell's Palsy
( ) Benign Tumors
( ) Bipolar
( ) Bowel Obstruction/Blockage
( ) Bronchitis
( ) Bulimia
( ) Bursitis
( ) Cancer
( ) Cataract
( ) Cerebral Palsy
( ) Cerebral Vascular Accident
( ) Cervical Spine Bifida
( ) Cirrhosis
( ) Colitis
( ) Coma
( ) Congestive Heart Failure
( ) Coronary Artery Disease
( ) Crohn's Disease
( ) Cystic Fibrosis
( ) Depression
( ) Diabetes
( ) Diverticulitis
( ) Down's Syndrome
( ) Embolism
( ) Emphysema
( ) Encephalitis
( ) Epilepsy
( ) Gastritis
( ) Glaucoma
( ) Heart Disease
( ) Hemophilia
( ) Hepatitis
( ) Hernia
( ) Herniated Disk
( ) Herpes
( )Histoplasmosis-Eye
( ) HIV sero-positive
( ) Human Papilloma Virus (HPV)
( ) Hyperlipidemia
( ) Hypertension
( ) Ileitis
( ) Irritable Bowel Syndrome
( ) Kidney Stones
( ) Leukemia
( ) Lupus
( ) Macular Eye Degeneration
( ) Meningitis
( ) Multiple Myeloma
( ) Multiple Sclerosis
( ) Muscular Dystrophies
( ) Osteoarthritis
( ) Osteomyelitis
( ) Osteoporosis
( ) Pancreatitis
( ) Parkinsons Disease
( ) Peritonitis
( ) Pheumonia, Whooping Cough
( ) Phlebitis
( ) Psychotic or Schizophrenic Disorders
( ) Pulmonary Heart Disease
( ) Rheumatic Heart Disease
( ) Rheumatoid Arthritis
( ) Scoliosis
( ) Septicemia
( ) Sickle Cell Anemia
( ) Sinusitis
( ) Spinal Cord Injury
( ) Spondylolisthesis
( ) Subdural hematoma
( ) Syphilis
( ) Thyroid Gland-hyper/hypo
( ) Tuberculosis
( ) Ulcer
( ) Ulcerative Colitis
( ) Varicose Veins
( ) Yeast Infections
( ) Lymphoma
( ) Thrombophlebitis

7. Miscellaneous

Social History
( )Smoking
( )Other Tobacco Use
( )Alcohol Use
( )Drug Use
( )Drink Coffee/Tea
( )Diet is: Balanced / Not Balanced
( )Rest is: Sufficient / Not Sufficient
( )Recreation is: Sufficient / Not Sufficient
( )My Family Stress is: Severe / Moderate / Minimal / None
( )How do you like work: I love it / It's OK / I hate it
( )My Job Stress is: Severe / Moderate / Minimal / None

8. Please list all present symptoms for the Musculoskeletal System

Head
( )Frequent headaches
( )Severe headaches
( )Head feels heavy
( )Vertigo
( )Light Headed
( )Loss of smell
( )Loss of taste
( )Loss of balance
( )Dizziness

Neck
( )Pain in Neck
( )neck pain with movement
( )swelling in neck
( )Stiff neck
( )Pinched nerve in neck
( )Neck feels out of place
( )Muscle spasms in neck
( )Grinding sounds in neck
( )Popping sounds in neck
( )Limited neck movement

Arms /Hands
( )Pain in upper arm
( )Pain in forearm
( )Pain in hands
( )Pain in fingers
( )Sensation of pins and needles
( )in arms
( )in fingers
( )Fingers go to sleep
( )Hands cold
( )Swollen joints in fingers
( )Sore joints in fingers
( )Loss of grip strength

Mid Back
( )Mid back pain
( )Pain between shoulder blades
( )Sharp stabbing pain
( )Dull Ache
( )Pain from front to back
( )Pain over kidney area
( )Muscle spasms in mid back

Low Back
( ) Low back Pain
( )Low back feels out of plac
( )Muscle spasms in low bac

Hips/Legs/Feet
( )Pain in buttocks
( )Pain down leg
( )Knee Pain
( )Leg cramps
( )Pins & Needles in legs
( )Numbness in leg
( )Numbness in toes
( )Cold feet
( )Swollen ankles
( )Swollen Feet

Shoulders
( )Pain in shoulders R/L
( )Pain across shoulders
( )Tension in shoulders
( )Muscle spasms shoulders
( )Cant raise arms
( )above shoulder level
( )over head

9. Have you ever been in an accident: yes/no

When was the Accident: _____ Injuries: _____

Type of Accident: Auto/Work-On Job/ At Home/Other