

Client Health Questionnaire

Name _____ Age _____ Date ____/____/____

Please describe your Current Complaint or Limitation: _____

Please describe how your problem began: _____

Please tell us how long ago your condition started: _____

List tests or other interventions for this condition that you have had: _____

Please indicate the daily activities that you cannot perform: _____

Please indicate your level of functioning prior to the onset of this condition: _____

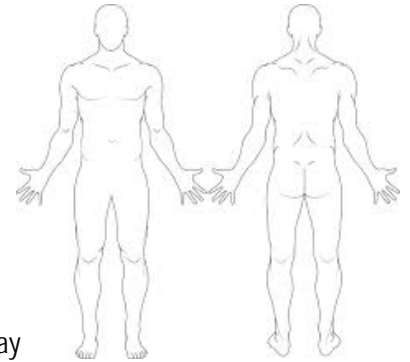
Please inform us of any environmental or living conditions that may have difficulties with: _____

Did you have surgery? No Yes Date ____/____/____ Procedure: _____

Please describe the nature of your symptoms (check **all** that apply):

- | | | |
|-------------------------------------------------|-------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> Sharp Pain | <input type="checkbox"/> Constant (76 – 100%) |
| <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Dull (Pain) Ache | <input type="checkbox"/> Frequent (51 – 75%) |
| <input type="checkbox"/> Imbalance | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Occasional (26 – 50%) |
| <input type="checkbox"/> Feeling "off" | <input type="checkbox"/> Numbness | <input type="checkbox"/> Intermittent (25% - or less) |
| <input type="checkbox"/> Ear Pressure/Pain | <input type="checkbox"/> Shooting | |
| <input type="checkbox"/> Motion intolerant | <input type="checkbox"/> Burning | |
| <input type="checkbox"/> Migraine/Headaches | <input type="checkbox"/> Tingling | |
| <input type="checkbox"/> Head Injury/Concussion | | |

Please Mark on the picture locations of pain



Level of symptoms at rest from 0 (No symptoms) to 10 (Unbearable symptoms) _____

Level of symptoms with activity from 0 (No symptoms) to 10 (Unbearable symptoms) _____

Since this condition began your symptoms have: decreased not changed increased

Your symptoms are worse in: morning afternoon night increased during the day same all day

Activities or positions that increase symptoms: _____

Activities or positions that decrease symptoms: _____

Occupation _____ Has your work status changed because of this condition YES NO

If you have ever had a listed condition in the past, please check it in the PAST column. If you are presently troubled by a particular condition, check it in the PRESENT column. The information you provide concerning past and present conditions and diseases assist your therapist in more thoroughly understanding your state of health.

PAST PRESENT

- | | | | |
|--------------------------|--------------------------|----------------------------|-------|
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure Angina | |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina | |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack | |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke | |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS | |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer – Location: | Date: |
| <input type="checkbox"/> | <input type="checkbox"/> | Tumor | |
| <input type="checkbox"/> | <input type="checkbox"/> | Systemic Lupus | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis | |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy | |
| <input type="checkbox"/> | <input type="checkbox"/> | Incontinence | |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco Use – packs/day: | |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug or Alcohol Dependence | |

Present: Weight _____ Height _____ ft _____ in.

Have you fallen in the last year? NO YES - If yes, how many? _____

Medication: (Name/Dosage/Frequency/Route Administered)

****If you need additional room for medications please bring a separate document on your next visit**

Hospitalization/Surgical Procedures (list if not described elsewhere):

Do you have a Pace Maker: NO YES