

## 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: \_\_\_\_\_

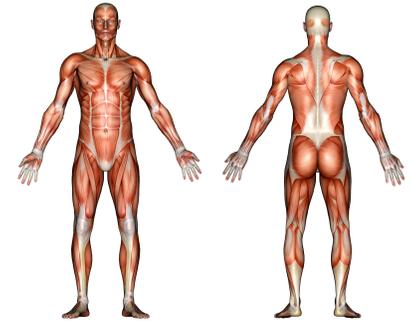
Please inform us of any environmental or living conditions that may have difficulties with: \_\_\_\_\_

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