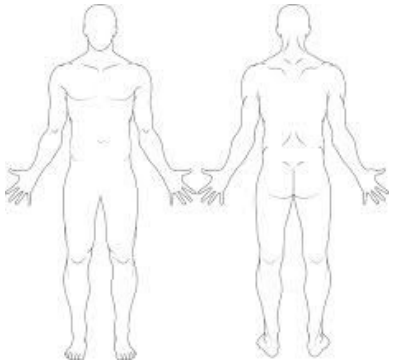
FYZICAL®

Client Health Questionnaire

Name _____Age _____ Date _____/_____/_____ Date of Birth _____/____/_____
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):

Please ark on the picture locations of pain



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

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	
____	____	High Blood Pressure
____	____	Angina
____	____	Heart Attack
____	____	Stroke
____	____	Asthma
____	____	HIV/AIDS
____	____	Cancer – Date:
____	____	Tumor
____	____	Systemic Lupus
____	____	Hepatitis
____	____	Epilepsy
____	____	Diabetes
____	____	Rheumatoid Arthritis
____	____	Arthritis
____	____	Pregnancy
____	____	Incontinence
____	____	Other_____
____	____	Tobacco Use – packs/day:
____	____	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):
_____
_____
_____
Have you ever been diagnosed with depression and/or Bipolar disorder? YES/NO
Do you have a Pacemaker: □NO □YES

Do you take vitamins? YES or NO How many hours of quality sleep do you get? _____
Would you like to lose weight? YES or NO
Are you interested in learning about a high quality, pharmaceutical grade line of supplements? YES or NO
Are you interested in learning about a natural anti-inflammatory? YES or NO
Are you interested in a healthy lifestyle program to help you change your lifestyle patterns? YES or NO