

_____/_____/_____
Patient's Name D.O.B. DATE

HEALTH QUESTIONNAIRE

This Information is Collected For Our Confidential Use Only

How did you hear about Chapin & Havlicek Physical Therapy? _____

Please check all conditions that you HAVE or HAVE HAD:

	Current	Past		Current	Past
1. arthritis	_____	_____	18. thyroid problem	_____	_____
2. neck/ back problems	_____	_____	19. headaches	_____	_____
3. balance disorder	_____	_____	20. depression	_____	_____
4. history of falls	_____	_____	21. anxiety/ panic attacks	_____	_____
5. faintness	_____	_____	22. alcohol dependency	_____	_____
6. fear of falling	_____	_____	23. drug dependency	_____	_____
7. heart disease	_____	_____	24. smoking history	_____	_____
8. high blood pressure	_____	_____	25. night sweats	_____	_____
9. circulatory problems	_____	_____	26. vision problems	_____	_____
10. pacemaker	_____	_____	27. hearing problems	_____	_____
11. jaw pain	_____	_____	28. bowel problems	_____	_____
12. respiratory problems	_____	_____	29. bladder problems	_____	_____
13. blood disorder	_____	_____	30. stomach disorder	_____	_____
14. stroke	_____	_____	31. amount of daily alcohol- servings: _____		
15. diabetes	_____	_____	32. amount of daily caffeine- servings: _____		
16. pregnant	_____	_____	33. OTHER: _____		
17. cancer	_____	_____			

Current stress level: ___ minimum ___ moderate ___ severe

Comments: _____

List any allergies you have: _____

List surgeries and approximate date: _____

Patient's Name

____/____/____
D.O.B.

____/____/____
DATE

Health questionnaire continued...

Please list all prescription medications, over the counter pills, vitamins, minerals and supplements including dosages for each: (please attach list if easier)

<u>MEDICATION NAME</u>	<u>DOSAGE</u>	<u>REASON FOR TAKING</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____
13. _____	_____	_____
14. _____	_____	_____
15. _____	_____	_____
16. _____	_____	_____
17. _____	_____	_____
18. _____	_____	_____
19. _____	_____	_____
20. _____	_____	_____

.....
By signing below, I verify that the information I have provided is complete and accurate and I have discussed this with the therapist.

Patient Signature

Date

Therapist Signature

Date