

Health Questionnaire

Name: _____ Age: _____ Date of Birth: _____ E-mail Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Occupation: _____ # Hours/Week Currently Working: _____ Marital Status: _____

Insurance Type: _____ Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Check off any of the following symptoms you have experienced in the past 6 months:

- | | | |
|---|--|--|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Tension Across Top of Shoulders | <input type="checkbox"/> Tired/Fatigued |
| <input type="checkbox"/> Pain between Shoulder Blades | <input type="checkbox"/> Numbness/Tingling in Arms/Hands | <input type="checkbox"/> Difficulty Sleeping |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Numbness/Tingling in Legs/Feet | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Tension/Headaches | <input type="checkbox"/> Pain in the legs | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Pain in the feet | <input type="checkbox"/> Carpal Tunnel |
| <input type="checkbox"/> OTHER (explain) _____ | | |

Which of the above is the worst? _____

How long have you had it? _____

How often does it occur? _____

What does it feel like?(describe) _____

What have you done that has helped this problem? _____

What activities would you like to do if this was not a problem? _____

Does this cause you to be:

- Moody
- Irritable
- Interrupt sleep
- Restricted in your daily activities

Does this affect your work:

- Decision making
- Poor attitude
- Decreased productivity
- Exhausted at the end of the day
- Unable to work long hours

Does this affect your life:

- Lose patience with spouse/children
- Restricted household duties
- Hinders ability to exercise or sports
- Interferes with ability to do hobbies or other activities

What have you tried to help relieve/get rid of this problem and how much did it help? (circle appropriately)

- | | |
|---|---|
| ◆ Medications...Helped: Little Some Much | ◆ Exercise...Helped: Little Some Much |
| ◆ Physical Therapy...Helped: Little Some Much | ◆ Nutrition...Helped: Little Some Much |
| ◆ Chiropractic...Helped: Little Some Much | ◆ Stretching...Helped: Little Some Much |
| ◆ OTHER _____ | Location: _____ Date: _____ |

I consent to receiving a health screening. I realize that I am not receiving a diagnosis, treatment or prognosis for any condition that I may be experiencing. I acknowledge that I am receiving a demonstration only and agree to hold harmless the therapist and/or clinic from any damage resulting from this demonstration.

Signature: _____ Date: ____/____/____

How did you hear about us? _____