HEALTH QUESTIONNAIRE

This information is required by your health care plan.

1. **Name:**_____ **Date of Birth:**_____**Current Height:**_____ **Current Weight:**_____ **BMI:**_____

2. **Have you had physical, occupational or speech therapy this year?** □ **Yes** □ **No** If yes, please provide date and location_____

Have you had or are you currently receiving home health services (nursing, home aids, etc.)? □ **Yes** □ **No**
If yes, please provide date, location and discharge date:_____
Outpatient therapy will be denied by insurance if you are currently receiving these services.

3. **With whom do you live?**
☐ Alone ☐ Spouse only ☐ Spouse and other(s) ☐ Child (not spouse)
☐ Other relative(s) ☐ Group setting ☐ Personal Care Attendant ☐ Other:

4. **GENERAL HEALTH STATUS**
a. Are you confident in your ability to overcome this problem?
☐ Yes ☐ No
b. Please rate your health:
☐ Excellent ☐ Good ☐ Fair ☐ Poor
c. Are you pregnant?
☐ Yes ☐ No ☐ Unsure
d. Do you exercise at least 3 times a week?
☐ Yes ☐ No

5. **SOCIAL/HEALTH HABITS**
Do you currently use tobacco? ☐ Yes ☐ No If yes, please specify_____

6. Do you regularly drink alcohol? ☐Yes ☐No If yes, please specify_____

7. **MEDICAL/SURGICAL HISTORY - Please check if you have ever had or are currently being treated for:**

☐ Arthritis ☐ High blood pressure ☐ DVT (deep vein thrombosis) ☐ AIDS
☐ Broken bones/fractures ☐ Head injury ☐ Heart Problems ☐ HIV
☐ Stroke ☐ Osteoporosis ☐ Low Blood Sugar/hypoglycemia ☐ TB (tuberculosis)
☐ Diabetes/high blood sugar ☐ Seizures/epilepsy ☐ Cancer ☐ Hepatitis
☐ Depression/Anxiety ☐ Neurological condition ☐ Chronic Lung Disease

8. **Within the past year, have you had any of the following symptoms? (Check all that apply.)**

☐ Chest pain ☐ Shortness of breath ☐ Other:_____
☐ Hoarseness ☐ Pain at night ☐ Nausea/vomiting
☐ Weakness in arms or legs ☐ Weight loss/gain ☐ Joint pain or swelling

Have you had surgery in the past 5 years? ☐ Yes ☐ No **If yes, please describe, and include date:**

Month_____ Year_____ _____
Month_____ Year_____ _____

Do you have any electrical implanted devices? (i.e. pacemaker, bone stimulator, urinary control stimulator, etc…) ☐ Yes ☐ No

9. **MEDICATIONS – Including prescriptions, over the counter, vitamins, supplements, etc.**
Please list: name, dosage, frequency, route or provide list.
_____
_____

10. **OTHER CLINICAL TESTS -** Within the past year, have you had any of the following tests related to your current complaints?

☐ Arthroscopy ☐ EKG (electrocardiogram) ☐ EMG (electromyogram) ☐ Stress test (e.g., treadmill, bicycle)
☐ Bone scan ☐ MRI ☐ Echocardiogram ☐ Other: _____
☐ CT Scan ☐ NCV (nerve conduction velocity) ☐ X-rays

I hereby certify that I have personally answered all of the questions on this form and that my answers are true and complete to the best of my knowledge and belief.

Date_____ **Patient Signature**_____