

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**

- a. Do you take any prescription medications including narcotic pain medications? Yes No
If yes, please specify: _____
- b. Do you take any non-prescription medications? Yes No If yes, please specify: _____

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 _____