HEALTH QUESTIONNAIRE

1. **Name:**____ **Date of Birth:**____________**Current Height:**_________ **Current Weight:**_________

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. Please rate your health:
☐ Excellent ☐ Good ☐ Fair ☐ Poor

b. Have you had any major life changes during the past year? (e.g., new baby, job change, death of a family member)
☐ Yes ☐ No

c. Are you pregnant?
☐ Yes ☐ No ☐ Unsure

5. **SOCIAL/HEALTH HABITS**

Do you currently smoke tobacco? ☐ Yes ☐ No If yes, how many packs or cigarettes/cigars per day?______________________

6. **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

7. **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
☐ Weakness in arms or legs ☐ Weight loss/gain
☐ Joint pain or swelling ☐ Nausea/vomiting

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

8. **MEDICATIONS**

a. Do you take any prescription medications? ☐ Yes ☐ No
If yes, please list:____
b. Do you take any non-prescription medications? ☐ Yes ☐ No If yes, please list:

9. **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**____