HEALTH HISTORY QUESTIONNAIRE

PATIENT NAME: _____DATE:_____

OCCUPATION: _____

LEISURE ACTIVITIES:

_____

LIST ANY MEDICATIONS YOU ARE ALLERGIC TO:

_____

_____

LIST ANY OTHER ALLERGIES WE SHOULD KNOW ABOUT:

_____

_____

ARE YOU LATEX SENSITIVE? YES☐NO ☐

HAVE YOU DECLARED THE ADVANCED CLINICAL DIRECTIVE OF "DO NOT RESUSITATE"? YES ☐ NO ☐

PLEASE CHECK ANY OF THE FOLLOWING WHOSE CARE YOU ARE CURRENTLY UNDER:

☐ MEDICAL DOCTOR (MD)
☐PSYCHIATRIST/PSYCHOLOGIST
☐ OSTEOPATH
☐PHYSICAL THERAPIST
☐DENTIST
☐CHIROPRACTOR
☐OTHER_____

IF YOU HAVE SEEN ANY OF THE ABOVE DURING THE PAST THREE MONTHS, PLEASE DESCRIBE FOR WHAT REASON(ILLNESS, MEDICAL CONDTION, PHYSICAL,
ETC.):_____

_____

_____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS? Check all that apply

☐ CANCER (if so, what type :_____)
☐ HEART PROBLEMS
☐ HIGH BLOOD PRESSURE
☐ CIRCULATION PROBLEMS
☐ ASTHMA
☐ EMPHYSEMA/BRONCHITIS
☐ CHEMICAL DEPENDENCY (i.e., alcoholism)
☐ THYROID PROBLEMS
☐ DIABETES
☐ MULTIPLE SCLEROSIS
☐ RHEUMATOID ARTHRITIS
☐ OTHER ARTHRITIC CONDITIONS
☐ DEPRESSION
☐ HEPATITIS
☐ TUBERCULOSIS
☐ STROKE
☐ KIDNEY DISEASE
☐ ANEMIA
☐ EPILEPSY
☐ OTHER please explain:

_____

_____

DURING THE PAST MONTH HAVE YOU BEEN FEELING DOWN, DEPRESSED OR HOPELESS? YES NO

DURING THE PAST MONTH HAVE YOU BEEN BOTHERED BY HAVING LITTLE INTEREST OR PLEASURE IN DOING THINGS YOU NORMALLY ENJOY? YES NO

DO YOU FEEL UNSAFE AT HOME OR HAS ANYONE HIT YOU OR TRIED TO INJURE YOU IN ANY WAY? YES NO

FOR WOMEN: ARE YOU CURRENTLY PREGNANT OR THINK YOU MAY BE PREGNANT? YES NO

PLEASE LIST ANY SURGERIES OR OTHER CONDITIONS FOR WHICH YOU HAVE BEEN HOSPITALIZED, INCLUDING THE APPROXIMATE DATE AND REASON FOR THE SURGERY OR HOSPITALIZATION

DATE	REASON FOR SURGERY/HOSPITALIZATION
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PLEASE DESCRIBE ANY SIGNIFICANT INJURIES FOR WHICH YOU HAVE BEEN TREATED (including fractures, dislocations, sprains)

DATE	INJURY
_____	_____
_____	_____
_____	_____
_____	_____

HAS ANYONE IN YOUR IMMEDIATE FAMILY (parents, brothers, sisters) EVER BEEN TREATED FOR ANY OF THE FOLLOWING? (Check all that apply)

___DIABETES
___HEART DISEASE
___STROKE
___CHEMICAL DEPENDENCY
___ARTHRITIS
___HEADACHES
___MENTAL ILLNESS
___TUBERCULOSIS
___HIGH BP
___KIDNEY DISEASE
___CANCER
___ANEMIA
___EPILEPSY

WHICH OF THE FOLLOWING OVER-THE-COUNTER MEDICATIONS HAVE YOU TAKEN IN THE LAST WEEK?
(Check all that apply)

___ASPIRIN ___TYLENOL
___IBUPROFEN ___LAXATIVES
___DECONGESTANTS ___ANTIHISTAMINES
___ANTACIDS ___VITAMINS/MINERALS
___OTHER:_____

PLEASE LIST ALL PRESCRIPTION MEDICATION YOU ARE TAKING, INCLUDING PILLS, INJECTIONS, AND/OR SKIN PATCHES:

1._____ 2._____
3._____ 4._____
5._____ 6._____

HOW MANY CAFFEINATED COFFEE OR CAFFEINE CONTAINING BEVERAGES DO YOU DRINK PER DAY? _____

HOW MANY PACKS OF CIGARETTES DO YOU SMOKE A DAY? _____

HOW MANY DAYS PER WEEK DO YOU DRINK ALCOHOL? _____

IF ONE DRINK EQUALS ONE BEER OR GLASS OF WINE, HOW MANY DRINKS DO YOU HAVE AT AN AVERAGE SITTING? _____

HAVE YOU RECENTLY NOTED ANY OF THE FOLLOWING? (Check all that apply)

___WEIGHT LOSS/GAIN
___NAUSEA/VOMITING
___DIZZINESS/LIGHTHEADEDNESS
___FATIGUE
___WEAKNESS
___FEVER/CHILLS/SWEATS
___NUMBNESS/TINGLING

_____ _____
Patient signature Date Therapist signature Date