

PERSONAL HEALTH QUESTIONNAIRE

NAME: (FIRST & LAST) _____ DATE: ___/___/___

INSTRUCTIONS: Please fill out this questionnaire as complete as possible. The more information we have the better we can design a more complete program to meet your needs. Your information will be fully protected and not shared with anyone outside of this facility unless you authorize us to do so. If you have any questions, please ask for assistance.

▪YOUR AGE: _____ ▪YOUR DATE OF BIRTH: ___/___/___ ▪GENDER: M F

▪YOUR OCCUPATION: _____

▪RATE IN TIME HOW YOU SPEND MOST OF YOUR DAY:
_____(HRS) SITTING _____(HRS) STANDING _____(HRS) MANUAL LABOR _____(HRS) LYING DOWN (SLEEP)
_____(MIN.) EXERCISE

▪DATE OF YOUR LAST PHYSICAL EXAMINATION: ___/___/___

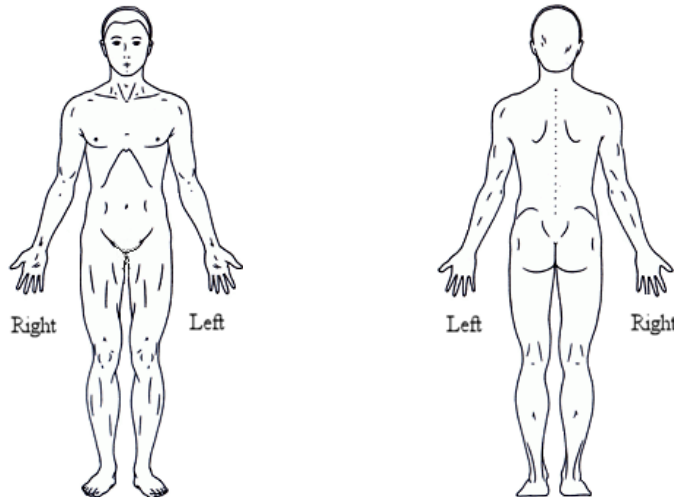
▪APPROXIMATE DATE OF YOUR LAST BLOOD EVALUATION: ___/___/___

▪APPROXIMATE DATE OF YOUR LAST XRAY OR MRI: ___/___/___

▪WHAT WERE THE RESULTS OF THE ABOVE TESTS?

▪DO YOU HAVE AN INJURY OR AREA OF PAIN? PLEASE DESCRIBE.

▪PLEASE DRAW ON THE BELOW BODY YOUR AREAS OF CONCERN.



▪If you have a chronic area of pain, please elaborate on the following?

WHERE?

WHEN DID IT START?

TREATMENT RECEIVED?

WHY DO YOU THINK IT HAS BEEN CHRONIC?

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Do you have now or have you had in the past 3 years: (PLEASE PLACE A "X" IN APPROPRIATE AREA)

| | | CURRENT | PAST | NEVER | FAMILY HISTORY |
|-----------------------------------------------------|-----------------------------------|---------|------|-------|----------------|
| Muscle/Joint/Bone (pain, numbness, weakness): | Neck | | | | |
| | Shoulders | | | | |
| | Arms | | | | |
| | Hands | | | | |
| | Back | | | | |
| | Hips | | | | |
| | Legs | | | | |
| | Feet | | | | |
| Cardiovascular: | Chest pain | | | | |
| | High blood pressure | | | | |
| | Irregular heart beat | | | | |
| | Low blood pressure | | | | |
| | Poor circulation | | | | |
| | Rapid heart beat | | | | |
| | Swelling of ankles | | | | |
| | Varicose veins | | | | |
| | Blood in urine | | | | |
| Genito-Urinary: | Frequent urination | | | | |
| | Lack of bladder control | | | | |
| | Painful urination | | | | |
| | Poor appetite | | | | |
| | Excessive appetite | | | | |
| Gastrointestinal: | Bowel changes | | | | |
| | Constipation | | | | |
| | Diarrhea | | | | |
| | Excessive thirst | | | | |
| | Excessive gas or bloating | | | | |
| | Indigestion frequently | | | | |
| | Hemorrhoids | | | | |
| | Rectal bleeding | | | | |
| | Nausea | | | | |
| | Stomach pain | | | | |
| | Vomiting | | | | |
| | Blurred vision/double vision | | | | |
| | Difficulty swallowing | | | | |
| | Earache with or without discharge | | | | |
| Ear, Nose, Throat: | Allergies/hay fever | | | | |
| | Hoarseness | | | | |
| | Loss of hearing | | | | |
| | Nosebleeds | | | | |

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| | | CURRENT | PAST | NEVER | FAMILY HISTORY |
|--------------------|--------------------------|---------|------|-------|----------------|
| | persistent cough | - | - | - | - |
| | Ringling in the ears | | | | |
| | Sinus problems | | | | |
| | Vision-flashes or halos | | | | |
| | Bruise easily | | | | |
| | Hives | | | | |
| | Excessive itching | | | | |
| | Change in moles | | | | |
| Skin: | Rash | | | | |
| | Scars | | | | |
| | Slow healing wound | | | | |
| | Chills | | | | |
| | Depression | | | | |
| | Dizziness | | | | |
| | Fainting | | | | |
| | Fever | | | | |
| General: | Forgetfulness | | | | |
| | Headache | | | | |
| | Loss of sleep | | | | |
| | Anxiety | | | | |
| | Nervousness | | | | |
| | Sweats | | | | |
| Men only: | Breast lump | | | | |
| | Erectile difficulties | | | | |
| | Lump in testicles | | | | |
| | Penis discharge | | | | |
| | Sore on penis | | | | |
| Women only: | Abnormal pap smear | | | | |
| | Bleeding between periods | | | | |
| | Breast lump | | | | |
| | Extreme menstrual pain | | | | |
| | Hot flashes | | | | |
| | Nipple discharge | | | | |
| | Painful intercourse | | | | |
| | Vaginal discharge | | | | |
| | Other: | | | | |

- Date of last menstrual period: ___/___/___
- Date of last pap smear & exam: ___/___/___
- Are you pregnant or think you may be pregnant?: ___YES ___NO
- Have you had any children?: ___YES ___NO

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▪DO YOU HAVE OR HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?:
(PLEASE MAKE AN "X" TO ANY "YES" ANSWERS)

- | | | | |
|---------------------------------------------|----------------------------------------------|---------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> CHEMICAL DEPENDENCY | <input type="checkbox"/> HIGH CHOLESTEROL | <input type="checkbox"/> PROSTATE PROBLEM |
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> CHICKEN POX | <input type="checkbox"/> HIV POSITIVE | <input type="checkbox"/> PSYCHIATRIC CARE |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> DIABETES | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> ANOREXIA | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> SCARLET FEVER |
| <input type="checkbox"/> APPENDICITIS | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> MEASLES | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> MIGRAINES | <input type="checkbox"/> SUICIDE ATTEMPT |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> GOITER | <input type="checkbox"/> MISCARRIAGE | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> BLEEDING DISORDERS | <input type="checkbox"/> GONORRHEA | <input type="checkbox"/> MONONUCLEOSIS | <input type="checkbox"/> TONSILITIS |
| <input type="checkbox"/> BREAST LUMP | <input type="checkbox"/> GOUT | <input type="checkbox"/> MULTIPLE SCLEROSIS | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> BRONCHITIS | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> MUMPS | <input type="checkbox"/> TYPHOID FEVER |
| <input type="checkbox"/> BULIMIA | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HERNIA | <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> VAGINAL INFECTION |
| <input type="checkbox"/> CATARACTS | <input type="checkbox"/> HERPES | <input type="checkbox"/> POLIO | <input type="checkbox"/> VENEREAL DISEASE |

▪Do you have ANY medical conditions not included in the list above: (please describe and list):

▪Please list any medications or supplements that you take, how often you take them, what you take them for, and if any of them affect heart rate or cardiovascular health:

▪Have you had any surgeries or hospitalizations in your lifetime? If YES please list when and what for:

▪Who are your primary and secondary medical providers (family physician, OBGYN, internist, psychiatrist, counselor, nutritionist, Chiropractor, Osteopath, Acupuncturist, etc...)

| | <u>NAME</u> | <u>LOCATION</u> | <u>TYPE OF CARE</u> |
|----|-------------|-----------------|---------------------|
| 1) | | | |
| 2) | | | |
| 3) | | | |
| 4) | | | |

▪WHAT IS YOUR REASON FOR YOUR VISIT TO OUR FACILITY? PLEASE DESCRIBE.

▪Do you get regular sleep? What is an average night sleep?

▪What do you do now for stress relief or relaxation?

▪Do you have any learning disabilities or cognitive challenges? If yes, please explain.

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▪WHAT IS YOUR *CURRENT* STRESS LEVEL: ___LOW ___MODERATE ___HIGH
▪WHAT IS YOUR *AVERAGE* STRESS LEVEL: ___LOW ___MODERATE ___HIGH

▪What type of shoes do you wear (on average)?:

- Shoe type at work:
- Shoe type while off work:
- Shoe type while out socially:
- Shoe type while exercising:.

Functional Measurements:

▪Does your area of concern limit you from doing things? If yes, please explain.

▪Please check any of the following that you think will help your area of concern:
___manual therapy ___exercise ___strength ___flexibility

▪Do you drink caffeine? If YES in what form, how much, and how often?

▪Do you have an addiction to refined sugar, artificial sugar, or carbohydrates? ___YES ___NO

▪Do you smoke cigarettes or medical use marijuana?: ___YES ___NO If YES, which one and how often? _____

▪Do you drink alcohol? ___YES ___NO, if YES, please list the types of alcohol and how often you consume them: _____

▪Do you do recreational drugs?: ___YES ___NO, if YES, how often: _____

▪Are you willing to make changes in your lifestyle to change your current fitness level? ___YES ___NO

I, _____(your name), I agree to immediately tell my doctor/therapist(s) at this facility of any medical conditions , injuries, or pregnancy. I have read, understood, and completed this questionnaire as complete as I am willing to disclose. I understand that if I have not disclosed items on this questionnaire it may affect the quality of my program design and further hinder my health progress.

Your first and last name

Your signature

date

Signature of parent or guardian if under age 18

Signature of PROGRESSION representative

date