

## Health Questionnaire

Please **CIRCLE** if you have or have had any of the following:

Osteoarthritis/Rheumatoid arthritis	High Blood Pressure
Broken Bones	Breathing problems/Asthma
Osteoporosis	Diabetes
Blood Disorders	Cancer
Circulation Problems	Infectious Diseases
Thrombophlebitis(blood clots)	Stomach/GI problems
Heart Problems	Stroke
Pacemaker/Defibrillator	Seizures
Neuromuscular disease (MS, MD)	Balance Problems

Other: (please list) \_\_\_\_\_

Please list all **medication** you are currently taking (and what they are for):

\_\_\_\_\_  
\_\_\_\_\_

**Allergies:** (please list) \_\_\_\_\_

### **SURGERY**

### **DATE**

All **surgeries** you have had: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you or could you be pregnant?    Yes    No

**PLEASE CIRCLE ONE NUMBER FOR EACH SCALE:**

**1. PAIN LEVEL:**

10	9	8	7	6	5	4	3	2	1	0
I have intolerable				I have moderate pain				I have no pain		
pain with all activities				with half my activities				with any activity		

**2. SEVERITY:** How much is this injury/condition “messing up” your life as a whole? Take into consideration all areas of you life.

10	9	8	7	6	5	4	3	2	1	0
My life is severely										My life is
affected										unaffected

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_