

The purpose of this questionnaire is to help us understand your health status. Please complete this form and your therapist will answer any questions during your exam. This form is considered part of your medical record.

<b>PATIENT NAME:</b>			
<b>1) When was your last general health check up?</b>			<b>Date:</b>
<b>2) Have you ever been told you have:</b>			<b>Therapist's Comments:</b>
High Blood Pressure			
Heart Problems	Yes	No	
Lung Problems	Yes	No	
Kidney Problems	Yes	No	
Head Injury	Yes	No	
Stroke/Neurological Problems	Yes	No	
Liver Problems	Yes	No	
Thyroid Problems	Yes	No	
Blood Disorders	Yes	No	
Diabetes (High Blood Sugar)	Yes	No	
Low Blood Sugar	Yes	No	
Past fractures\dislocations	Yes	No	
Asthma	Yes	No	
Seizure	Yes	No	
Cancer	Yes	No	
Arthritis	Yes	No	
Shingles	Yes	No	
Ringing Ears	Yes	No	
Tuberculosis or Hepatitis	Yes	No	
Repeated Infections	Yes	No	
Depression	Yes	No	
Osteoporosis	Yes	No	
Circulation\Vascular Problems	Yes	No	
Ulcer/Stomach Problems	Yes	No	
<b>3) For Men Only</b>			
Prostate Disease	Yes	No	
<b>4) For Women Only</b>			
Pelvic Inflammatory Disease	Yes	No	
Endometriosis	Yes	No	
Are you pregnant?	Yes	No	
<b>5) Have You Recently Had:</b>			
Unexplained Weight Loss/Gain	Yes	No	
Loss of Appetite	Yes	No	
Unexplained Fever or Chills	Yes	No	
Unremitting Night Pain	Yes	No	
Joint Pain or Swelling	Yes	No	

Urinary or Bowel Problems	Yes	No	
Fatigue/Malaise/Tiredness	Yes	No	
Numbness or Tingling	Yes	No	
Weakness in Arms or Legs	Yes	No	
Recent Falls or Loss of Balance	Yes	No	
Coordination Problems	Yes	No	
Difficulty Walking	Yes	No	
Dizziness or Loss of Consciousness	Yes	No	
Chest Pain	Yes	No	
Heart Palpitations	Yes	No	
Shortness of Breath	Yes	No	
Difficulty Swallowing	Yes	No	
New Onset of Headaches	Yes	No	
Visual Problems	Yes	No	
Hearing Problems	Yes	No	
Hoarseness	Yes	No	
Cough	Yes	No	
6) Do You Smoke?	Yes	No	If yes, how many?      Packs/day
7) List any hospitalizations/Surgeries:			
8) List any other medical problems:			
9) Any allergies?			
10) List your current medications:			
11) Have you had a bone density test?    Yes / No			
12) Reviewed by:			

**Treatment Authorization for Vital Energy Occupational Therapy & Wellness Center:**

I acknowledge I have answered the above information to the best of my knowledge. I voluntarily consent and agree to actively participate in such services as assessments, treatments, personal care, and therapeutic exercise on land or in water prescribed by the staff of Vital Energy Occupational Therapy & Wellness Center and will not hold them responsible or liable for any adverse effect, harm, or side effects.

Signature \_\_\_\_\_ Date \_\_\_\_\_