Health Questionnaire
Integrated Physical Medicine

Patient Information

Date: _____

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Blood Pressure: _____

List all prescription, non-prescription medications, and other supplements (with dose) taken as well as the named condition:

□ I am currently NOT taking any prescription medication _____

_____

_____

List any surgeries or hospitalizations you have had complete with the month and year for each:

□ I have NEVER had surgery □ I have NEVER been hospitalized _____

_____

_____

List anything you are allergic to (medication, foods, environmental): □ No known allergies_____

Family History (grandparents, father, mother, siblings, children) - please list major diseases such as high blood pressure, cancer, diabetes, heart problems, bone/joint diseases, and the relation to you of the individual:

_____

_____

Do you exercise? □ Yes □ No Hours per week _____What activity(s)? _____

_____

Do you have a gym membership? □ Yes □ No If Yes, which location(s)? _____

Are you dieting? □ Yes □ No Since:_____ Do you smoke? □ Yes □ No □ Every day □ Some days _____ packs per day.

How many years have you been smoking? _____ Do you drink alcoholic beverages? □ Yes □ No _____ drinks per day.

Do you wear? □ Heel lifts □ Arch supports □ Prescription Orthotics

For women: Are you pregnant or nursing? □ Yes □ No If pregnant, how many weeks? _____

Date of last menstrual period: _____

Medical History

Describe the reason(s) for your doctor visit today:

_____

_____

_____

_____

Are you here because of an accident? _____What type? _____

When did your symptoms start? _____ How did your symptoms begin? _____

_____

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

Describe your symptoms? (Circle all that apply) Sharp Dull Ache Numbing Burning Tingling Stabbing Shooting

Are your symptoms? (Circle one) Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities?_____

_____

_____

Have you experienced these symptoms in the past?_____

_____

_____

Who may we thank for referring you to us? _____

History of Treatment

Primary care physician: _____ Phone: _____

Date last seen: _____ May we update them on your condition? ___Yes ____ No

Have you seen a Chiropractor or Physical Therapist or Massage Therapist before? ___ Yes ___ No

If you have you seen another doctor for these symptoms, please indicate name and type of medical provider: _____

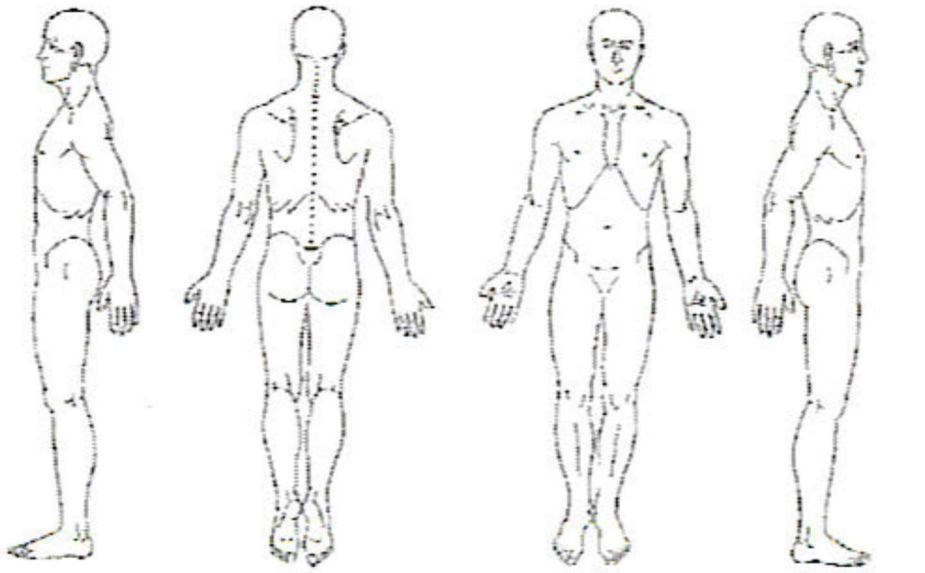
_____

In the past 6-12 months, have you had either an x-ray or MRI or CT scan? ____ Yes ____ No Region: _____

Description of Condition

Mark any area(s) of discomfort with the following key:

A =Ache N =Numbness B = Burning T = Tingling S = Stiffness O = Other



Left Back Front Right

On a scale of 1 to 10 how intense are your symptoms RIGHT NOW? Not intense ⓪①②③④⑤⑥⑦⑧⑨⑩ Unbearable

On a scale of 1 to 10 how intense are your symptoms AT REST? Not intense ⓪①②③④⑤⑥⑦⑧⑨⑩ Unbearable

On a scale of 1 to 10 how intense are your symptoms WITH ACTIVITY? Not intense ⓪①②③④⑤⑥⑦⑧⑨⑩ Unbearable

For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
○	○	Abdominal Pain	○	○	Elbow/upper arm pain	○	○	Liver/Gall Bladder Disorder
○	○	Abnormal Weight gain/loss	○	○	Epilepsy	○	○	Loss of Bladder Control
○	○	Allergies Headache	○	○	Excessive thirst	○	○	Low back pain
○	○	Angina/chest pain	○	○	Frequent Urination	○	○	Mid back pain
○	○	Ankle/foot pain	○	○	General Fatigue	○	○	Neck pain
○	○	Arthritis	○	○	Hand pain	○	○	Painful Urination
○	○	Asthma	○	○	Heart attack	○	○	Prostate Problems
○	○	Bladder Infection	○	○	Hepatitis	○	○	Shoulder pain
○	○	Birth Control Pills	○	○	High blood pressure	○	○	Smoking/tobacco use
○	○	Cancer	○	○	Hip/upper leg pain	○	○	Stroke
○	○	Chest Pains	○	○	HIV/AIDS	○	○	Systematic Lupus
○	○	Chronic Sinusitis	○	○	Hormone Therapy	○	○	Thoracic Outlet Syndrome
○	○	Depression	○	○	Jaw pain	○	○	Tumor
○	○	Dermatitis/Eczema	○	○	Joint swelling/stiffness	○	○	Ulcer
○	○	Diabetes – Type I/Type II	○	○	Kidney Stones	○	○	Upper back pain
○	○	Drug/Alcohol Use	○	○	Knee/lower leg pain	○	○	Wrist pain

Additional comments you would like the doctor to know: _____

Patient's Signature: _____ **Doctor's Signature:** _____

Date ROS Reviewed With The Patient: _____