Helm
Physical Therapy
& Injury Prevention

HEALTH SCREENING QUESTIONNAIRE

Name: _____ Age:_____ Date: _____

Leisure activities, including exercise routines: _____

Occupation and daily work activities: _____

Are you latex sensitive? O Yes O No Do you smoke? O Yes O No

For women: Are you currently pregnant or think you might be pregnant? O Yes O No

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Have you RECENTLY noted any of the following (check all that apply)?

- O fatigue
- O muscle weakness
- O nausea/vomiting
- O unexplained weight loss/gain
- O difficulty maintaining balance while walking
- O changes in bowel or bladder function
- O numbness or tingling
- O fever/chills/sweats
- O dizziness/lightheadedness
- O heartburn/indigestion
- O difficulty swallowing
- O vision changes
- O cough
- O falls
- O shortness of breath
- O fainting
- O headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- O cancer
- O heart problems
- O chest pain/angina
- O high blood pressure
- O circulation problems
- O blood clots
- O stroke
- O anemia
- O bone or joint infection
- O chemical dependency (i.e., alcoholism)
- O depression
- O lung problems
- O tuberculosis
- O asthma
- O rheumatoid arthritis
- O other arthritic condition
- O bladder/urinary tract infection
- O kidney problem/infection
- O HIV
- O thyroid problems
- O diabetes
- O osteoporosis
- O multiple sclerosis
- O epilepsy
- O ulcers
- O liver problems
- O hepatitis
- O pneumonia

Do you have a pacemaker? O Yes O No

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- O cancer
- O stroke
- O blood clots
- O diabetes
- O thyroid problem
- O heart problems
- O high blood pressure

Please list ANY medications you are currently taking (INCLUDING pills, injections, and/or skin patches). You may attach a list if needed:

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Have you ever taken steroid medications for any medical condition? O Yes O No

Have you ever taken blood thinning or anticoagulant medications for any medical reason? O Yes O No

If so, when?_____

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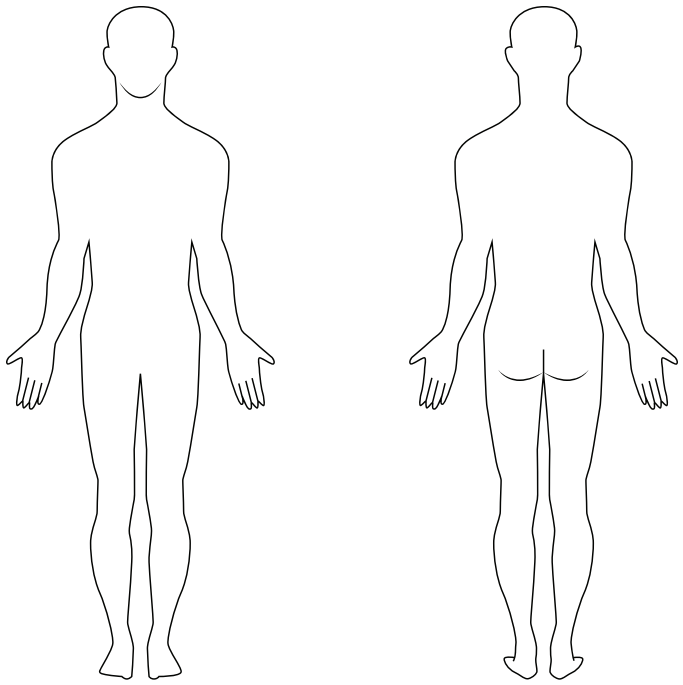
Body Chart:
Please mark the areas where you feel symptoms on the chart to the right using the following symbols to describe your symptoms:

↓	**Shooting/sharp pain**
O	**Dull/aching pain**
///	**Numbness**
=	**Tingling**



My symptoms currently:

- O Come and go
- O Are constant
- O Are constant, but change with activity

Using the 0 to 10 scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:

Your current level of pain while completing this survey: _____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____

Have you received any treatment for this problem before today (chiropractic care, injections, etc.)?_____

_____

_____

Please list any specific tests performed for this problem (x-ray, MRI, labs, etc.): _____

_____

_____

Have you ever had this problem in the past? O Yes O No **When?**_____

What treatment have you received in the past? _____

_____

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