HEALTH INQUIRY FORM

Please complete the following information:

	____/_____/_____ MM / DD / YYYY
Client Name	**Date of Birth**

☐ Male ☐ Female	Ft. In.	Lbs.
Sex	**Ht.**	**Wt.**

1. Have you ever been diagnosed with one of these conditions? (check all that apply)

- ☐ Diabetes requiring Insulin
- ☐ Peripheral Vascular Disease
- ☐ Carotid Artery Disease
- ☐ Skin Ulcers
- ☐ Stroke or Transient Ischemic Attack (TIA)
- ☐ Alzheimer's Disease, Lewy Body Disease, or Dementia
- ☐ Psychosis or Schizophrenia
- ☐ Mental Retardation
- ☐ Amyotrophic Lateral Sclerosis (ALS) or Myasthenia Gravis
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease or Parkinsonism
- ☐ Post-Polio Syndrome
- ☐ Demyelinating Disease
- ☐ Lupus (SLE)
- ☐ Mixed Connective Tissue Disease
- ☐ Scleroderma
- ☐ Muscular Dystrophy
- ☐ Amputation-Due to Disease
- ☐ Double Heart Valve Replacement
- ☐ Organ or Bone Marrow Transplants
- ☐ Kidney Disease or Polycystic Kidney Disease
- ☐ Cirrhosis of the Liver
- ☐ Hepatitis B, C, D, or E
- ☐ Hemachromatosis
- ☐ Metastatic Cancer
- ☐ Multiple Myeloma
- ☐ Brain or Spinal Cord Tumors
- ☐ AIDS
- ☐ Neurological Conditions affecting the brain or spinal cord
- ☐ Muscular Conditions Causing Functional Limits

2. Do you have any surgeries planned or recommended? ☐ **Yes** ☐ **No**

Provide details of Type of Surgery and When is it scheduled:

3. Have you been hospitalized or had any ER visits in the last year? ☐ **Yes** ☐ **No**

Provide the Dates and Reasons:

4. Have you ever been on disability? ☐ **Yes** ☐ **No**

Provide details:

5. Any Special tests or x-rays scheduled? ☐ **Yes** ☐ **No**

Provide details:

6. Do you have a handicapped parking tag? ☐ **Yes** ☐ **No**

If yes, why?

7. Have you ever been turned down for any insurance coverage? ☐ **Yes** ☐ **No**

If Yes—Give Type of Insurance, Date, and Reason:

8. List all other medications you are taking		☐ Check here if You DO NOT TAKE ANY MEDICATIONS	
Name of Medication	**What type of MD prescribed?** *(i.e. cardiologist, oncologist etc.)*	**For What Condition**	**How long Taking**

9. Have you been prescribed any medications you are not taking? ☐ Yes ☐ No
If Yes—Provide Details (i.e. name of medication, who prescribed, for what condition, why not taking it):

10. When was the last time you saw your primary physician and why?	
Date Last Seen:	**Reason:**

11. List any specialists you have seen in the last 5 years.		
Type of Specialist	**Month/Year last seen**	**Reason for Visit**
1.		
2.		
3.		