# DEFINED HEALTH PATIENT QUESTIONNAIRE

Name: ..... D.O.B. .....

Address: .....

Phone: .....

Email Address: .....

Who referred you to us? .....

Regular physician: Dr ..... who practices at .....

Are you currently under any other therapist or practitioner's care? No/Yes (Reason).....
.....

Allergies? No/Yes.....

If female do you think you might be pregnant? No/Yes – Due date: .....

Occupation: .....

Previous occupation (if applicable):.....

Smoker: Ex / No / Yes ..... Per day Alcohol: Never/Yes .....drinks per week

Current exercise and how often per week? .....
.....

Other type of activity or exercise in the past? .....
.....

On a scale of 1-10 rate your stress level (1 = None / 10 = Extreme)

Occupational ..... Personal.....

Please list any Pharmaceutical products you currently take

| DRUG NAME | Reason used |
|---|---|
| | |
| | |
| | |

**Current and Past Conditions / Injuries**

- ☐ Arthritis
- ☐ Asthma/breathing problems
- ☐ Osteoporosis
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy/seizures
- ☐ Fractures
- ☐ Heart conditions
- ☐ High/low blood pressure
- ☐ Infectious disease (hep, hiv, herpes)
- ☐ Insomnia
- ☐ Joint injuries
- ☐ Menstrual problems
- ☐ Recent impacts/traumas
- ☐ Recurring headaches
- ☐ Sudden weight change
- ☐ Surgery – any type
- ☐ Sweats or fevers
- ☐ Other problems .....

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PLEASE DESCRIBE YOUR CURRENT SYMPTOMS .....

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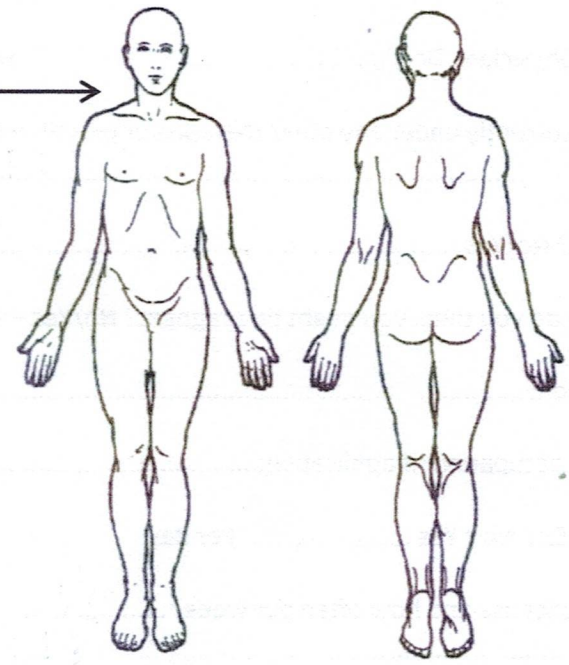
PLEASE INDICATE WHERE YOU FEEL THE MAIN FOCAL AREA/S OF PAIN / DISCOMFORT →

MAIN PAIN **X**



What triggered the problem? .....

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When did THIS EPISODE start? .....

What makes the pain worse? .....

What relieves the pain? .....

Have you had any tests for this complaint? .....

Is there anything else about your physical or medical history that you feel we should know about?

.....

THE STATEMENTS MADE ON THIS FORM ARE ACCURATE TO THE BEST OF MY KNOWLEDGE.

I UNDERSTAND THAT NO ACCOUNTS ARE KEPT BY THIS CLINIC AND PAYMENT WILL BE MADE AT THE END OF EACH VISIT

Signature ..... Date .....