



HEALTH HISTORY QUESTIONNAIRE

Email address: _____ (so that we may send you appointment reminders)

**** Have you been exposed to anyone with a fever, symptoms or a positive Covid test in the last 14 days? _____ Yes _____ No**

Are you experiencing/ have ever experienced any of the following:

Yes No

- Breathing problems/COPD
- High Blood Pressure/Heart problems/Pacemaker
- Dizziness/Fall in past 6 months
- Diabetes
- Spinal Injury / Back problems requiring medical attention
- Stroke/CVA/TIA
- Kidney issues/Loss of bowel or bladder control
- Joint replacement surgery
- Epilepsy/Seizure in past 6 months
- Head Injury/Memory Loss
- Multiple Sclerosis
- Arthritis/Pain in Joints/Fibromyalgia
- Dementia / Alzheimers
- Pregnancy (Due date: _____)
- Difficulty Swallowing*
- Mental illness/Depression
- Implanted electrical device / pain pump / mechanical device
- HIV/AIDS
- Cancer (location: _____)
- Osteoporosis/Osteopenia

**** Please be prepared to pay your co-pay on each visit. This amount is determined by your insurance company for services received.**

Other: _____

1. Please list current medications: (copy provided and scanned) _____

2. Are you allergic to: Bee stings Yes / No Latex Yes / No Menthol products Yes / No
Biofreeze Yes / No Cortisone Yes / No Cocoa Butter Yes / No

Please list other allergies: _____

3. Have you ever had any surgeries? Yes / No If Yes, please list all previous surgeries:

4. Are you currently receiving any care at your home/residence from an outside agency? **Yes/No**. If yes, which agency?_____. **If you do not notify us if your status changes and we receive a denial from Medicare due to overlapping services, you will be responsible for payment of this bill.**

5. _____
Patient Signature Height Weight Date