Personal Health Questionnaire

Date _____

Name _____

Work _____

Home _____

Cell _____

Mailing Address _____

Age _____ **Birthdate** _____

Life Occupation _____

Email _____

Emergency Contact: Name _____ **Phone:** _____

Referred by: _____ **Onset or Date of Injury**: _____

REASON for treatment:

_____

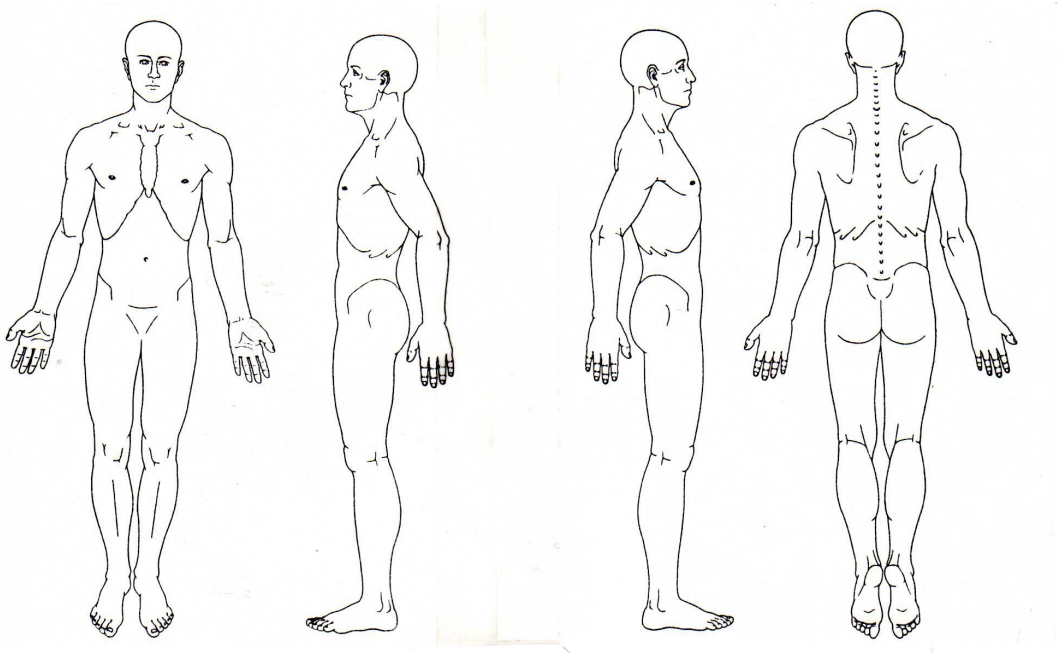
_____

Your GOALS for treatment: (What daily activities would you like to participate in you may have eliminated or postponed?)

_____

_____

MARK PROBLEM AREAS on diagram below:



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DEGREE OF CURRENT SENSATION:

(Circle) None < 1 2 3 4 5 6 7 8 9 10 > Most

DESCRIBE SENSATION or SYMPTOM:

Circle all that apply: _SHARP _NUMB _ACHEY _TINGLING _SHOOTING PAIN _SWELLING _BURNING _RADIATING or Other

_____

Constant? Y _N _ Intermittent? Y _ N _ Duration_____

Since Onset, Has Symptom? Increased__ Decreased__ Stayed the Same__

MODIFYING FACTORS:

What increases sensation? (change of posture, walk, sit, stand, etc.)

_____

What helps sensation? (ice, heat, change of posture, activity, etc.)

_____

TREATMENT AND TESTS:

What TREATMENT have you had for this?

_____

_____

_____

What MEDICAL DIAGNOSTIC TESTS have you had for this? MRI, PetScan, X-ray, Ultrasound, EMG, EKG, EEG, Endoscopy, etc.

_____

_____

_____

List ALL Surgeries and Hospitalizations:

_____

_____

_____

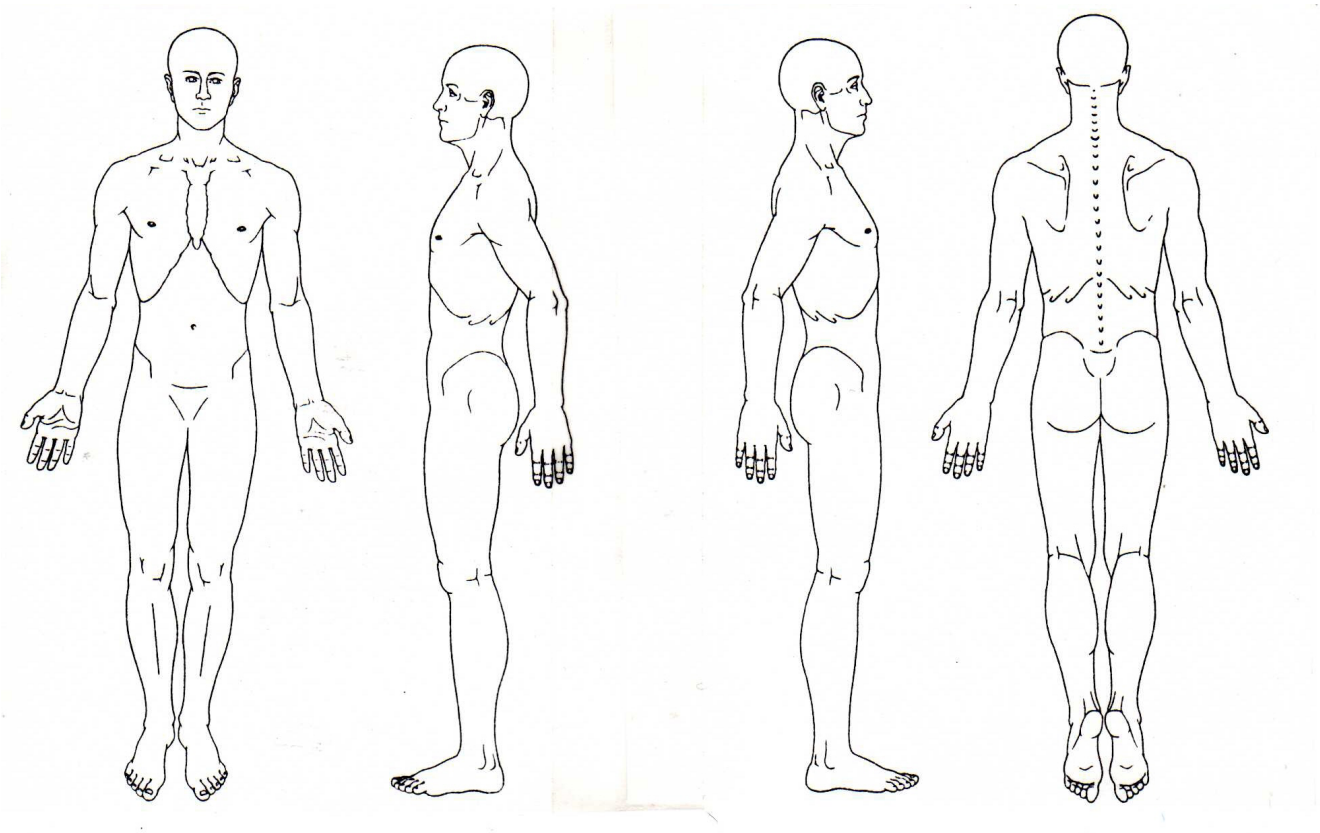
List ALL major Accidents and Injuries, (Broken Bones, Whiplash, etc). (including all during childhood):

_____

_____

_____

MARK ALL Surgical Incision Sites, Laparoscopies, Epidurals, Cortisone, Botox or other Injections on diagram below:



List DOSE and FREQUENCY of ALL Medications, Supplements, Hormone Replacement, etc. which you currently take: (including Aspirin)

_____

_____

_____

_____

_____

_____

(Attach additional pages if needed.)

ADD DATE OF DIAGNOSIS OR ONSET AND DESCRIPTION FOR THOSE CONDITIONS THAT APPLY:

Muscle/Joint pain or stiffness/swelling	Vomiting
Numbness or Tingling	Nausea
Swelling	Clay/Chalky/Black/Tarry Stools
Cancer	Blood in Stools
Celiac Disease	Hemorrhoids
High/Low Blood Pressure	Digestive Conditions (Crohn's Disease, irritable bowel)
Breath shortness/Asthma	Gas/Bloating/Constipation
Stroke/Heart Attack	Diarrhea, Dysentery
Varicose Veins	Ulcers
Ear Ringing	Trouble Swallowing
Headaches/Migraines	Dizziness
Deep Bruises	Vision Loss/Changes
Epilepsy/Seizures	Blood in Urine
Acid Reflux or GERD	Bladder feels full, not much urination
Chest Pain	Burning with urination
Soaking Sweats, sweaty hands and/or feet	Interstitial Cystitis
Neurological Conditions (MS, Parkinson's, Neuropathy, etc.)	Diabetes (Type I or II)
Sleep Apnea	Restless Leg Syndrome
Kidney Disease/Infection	Insomnia/Sleep Disorders
Bladder Disease/Infection	Ehlers Danlos Syndrome
Degenerative Spine/Disk	POTS or Dysautonomia
Broken Bones	PTSD/Trauma
Depression/Anxiety	Chronic Fatigue
Osteoporosis/Osteopenia	Arthritis
Scoliosis	Chronic Pelvic pain
Thyroid/Endocrine Condition	Fibromyalgia
Memory Loss	Multiple Chemical Sensitivities
Easily Overwhelmed	High Cholesterol
Blood Clots	Brain Injury or Concussion
Lyme Disease	Prostatitis/prostate surgery

GENERAL MEDICAL:

Contact lenses? Y_ N _
Dentures? Y_ N _ Upper _ Lower _ Both _
Hairpiece? Y_ N _
Pacemaker? Y_ N _
Flat Feet, High Arch or use Orthotics? Circle which apply
Known Allergies? Y __ N __ Describe
Hormone pellets? Y _ N _
Joint replacement hardware? Y_ N _ Describe if Yes
Surgical mesh? Y__ N__ Describe if Yes
IUD or other implanted contraceptive devices? Y _ N _
Hysterectomy? Y __ N __ Date
Pregnant? Y _ N _ How many Pregnancies? Deliveries? vaginal or c-section
Do you smoke? Marijuana _ Cigarettes _ Y_ N_ #Per Day ___ How many years?
Ever smoked? Y_ N _ When did you quit?
Drink alcohol? Y_ N _ How many drinks per week?_____ Month_____
HIV/AIDS Diagnosis? Y _ N _ Date of diagnosis

Payment and Cancellation Policy:

- PAYMENT FOR TREATMENT IS DUE AT TIME OF SERVICE. No insurance processing available.
- FULL FEE charged for MISSED APPOINTMENTS and CANCELLATIONS WITH LESS THAN 24-hour notice.
- COVID-19, FLU or COLD: If for any reason you feel unwell, now or recently have had any respiratory or flu symptoms, dry cough, sore throat, shortness of breath, or temperature of 100F or above now or in the 24 hours prior to your appointment, have been in contact with anyone in the last 5 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms, please contact me immediately to reschedule with no penalty.

Consent For Treatment:

- I understand bodywork practitioners are not qualified to perform medical examination, diagnose, prescribe, or treat any physical or mental illness and that I should see a qualified physician for any mental or physical ailment of which I am aware. If I experience any discomfort during my session, I will immediately inform the practitioner. I agree to keep the practitioner updated as to any changes in my health profile and affirm I have stated all my known medical conditions and answered questions honestly. I understand that, because manual therapy work involves maintained touch and close physical proximity over an extended period of time during a session, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and I agree and give consent to receive manual therapy and bodywork from Gigi Willett, LMT.

_____

Signature or Guardian, (relationship to client _____) **Date**