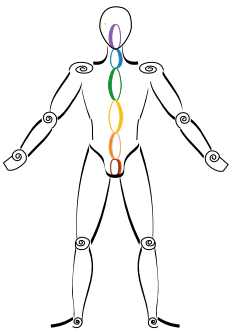

Orthopedic and TMJ Physical Therapy Center
Confidential Health Questionnaire

Name:_____ D.O.B.: _____

Date: _____ Occupation: _____

General Health Questions

1. Have you ever had any of the following conditions or problems? Be descriptive when appropriate.

- ❍ Anemia
- ❍ Arthritis
- ❍ Asthma
- ❍ Cataracts
- ❍ Cancer
- ❍ Chest Pains
- ❍ Circulatory problems
- ❍ Constipation/Impaction
- ❍ Convulsions
- ❍ Diabetes
- ❍ Digestive problems
- ❍ Dizziness
- ❍ Eliminatory problems
- ❍ Falls
- ❍ Fractures
- ❍ Head aches
- ❍ Head Injuries
- ❍ Heart condition
- ❍ Hemophilia
- ❍ Hemorrhoids
- ❍ High/low blood pressure
- ❍ HIV, AIDS
- ❍ Irritable Bowel
- ❍ Kidney/Bladder Stones
- ❍ Migraines
- ❍ Mitral valve prolapse
- ❍ Multiple Sclerosis
- ❍ Osteoporosis
- ❍ Osteomyelitis
- ❍ Pacemaker
- ❍ Parkinson's Disease
- ❍ Polyps
- ❍ Phlebitis
- ❍ Pregnancy Trauma
- ❍ Renal Diesase
- ❍ Respiratory problems
- ❍ Seizures
- ❍ Skin Conditions
- ❍ Thyroid problems
- ❍ Vascular Disease
- ❍ Musculoskeletal
  - ❍ TMJ ❍ Shoulders
  - ❍ Neck ❍ Hips
  - ❍ Back ❍ Knees
  - ❍ Feet

Other _____

_____

_____

_____

2. Hours of sitting per day (computer + driving) _____
3. When was your last Medical exam? ❍ Within last month ❍ Within last 6 months ❍ More than 6 mo.
4. Do you Smoke? ❍ Yes ❍ No
5. Education ❍ High School ❍ College ❍ Graduate ❍ Professional Training
6. Are you currently under the care of a physician/chiropractor/therapist/acupuncturist, counselor… etc. ?
   Provider's Name & Specialty

   _____

   _____

   _____
7. Please list all medications you are currently taking (prescription and over the counter)?
   Name & Dosage Reason for taking

   _____ _____

   _____ _____

_____ _____

_____ _____

8. Do you drink alcohol (if so list # per week)? ❍ No _____Beer. ____Wine. ____Spirits.
9. Indicate what amount you drink of the following in a typical day. ____Water (8oz.) ____Juice (8oz.) ____ Coffee (cups) ____ Tea (cups) ____ Soda (8oz.)
10. Have you ever been treated for any of the following:

- ❍ Anxiety
- ❍ Depression
- ❍ Drug Addiction
- ❍ None of the above
- ❍ Nervous Problems
- ❍ Constipation
- ❍ Heart Burn

11. Do you experience:
    - ❍ Numbness/tingling/weakness in anywhere in your body
    - ❍ Urinary leaking or urge with exercise, laughing, coughing, or on the way to the bathroom
    - ❍ Pain with urination or sexual activity
    - ❍ Clicking, popping or pain in your jaw
    - ❍ None of the above
12. Please list any past accidents and surgeries, (include dates if possible): _____
    _____
    _____
    _____
13. Please list in any past injuries, including falling on your coccyx/tailbone, that resulted in pain or limitation in sitting (including dates if possible): _____
    _____
    _____
14. Check all that apply: ❍ Face/brow lift ❍ Cheek/chin implants ❍ Breast augmentation/reduction
15. Have you ever seen a physical therapist before? ❍Yes ❍No
16. Please list exercise, sports, hobbies or musical instruments_____
    _____
    _____
17. Please describe your diet._____
    _____
    _____
18. Please list food, medication or other allergies: _____
    _____
    _____
19. Please describe your sleeping habits (Snoring, # of hours, position, # of pillows)_____
    _____
20. How did you hear about our clinic?_____
21. Please describe in your own words your pain pattern or concerns
    _____

_____

_____

_____

22. **Life Impairment:** What are your feelings about your problem on a scale of 1 to 10?

No Impairment 0 1 2 3 4 5 6 7 8 9 10 Severe Impairment