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HEALTH SCREENING

LAST NAME_____ FIRST NAME_____ PHONE #_____ DATE_____

Height _____ Weight _____ Are you interested in a wellness program? YES ___ No ___

PLEASE CIRCLE CURRENT PAIN LEVEL (0 = NO PAIN, 10 = SEVERE PAIN) 0 1 2 3 4 5 6 7 8 9 10

CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW
Aneurysm				Difficulty in walking			
Anemia				Double vision/Loss of vision			
Arthritis				Epilepsy, Seizures			
Back injury/ problems				Emphysema/COPD / Asthma			
Broken Bone				Excessive bleeding			
Bursitis				Fall in the last 6 months			
Bruise easily				Fatigue / Weakness			
Blood clots				Fever/ chills			
Blood in stools/urine				Foot/Ankle injury/ problems			
Bladder problems/ infection				Gall bladder problems/Gallstones			
Bone or joint infection				Gout			
Cramps in your legs				Heart palpitation or pounding			
Circulation problems				High / Low blood pressure			
Chronic cough				Heart problems/CHF/Valves			
Cancer				Hepatitis /Jaundice/ Liver disease			
Chronic headaches/Migraines				Hyper/Hypo Thyroid			
Constipation/Diarrhea				Hernia			
Difficulty breathing				Hip problems/injury/surgery			
Difficulty swallowing				Hand problems/injury/surgery			
Diabetes				Head injury/brain injury			
Depression/Anxiety				Joint/Muscle swelling			
Dizziness, Lightheadedness				Joint replacements			
Dominant Hand? Circle One				**Right** **Left**			

HAVE YOU EVER / DO YOU (PLEASE CHECK EACH ITEM AND FILL IN THE BLANK)

CHECK EACH ITEM	YES	NO	CHECK EACH ITEM	YES	NO
Lived with anyone who had tuberculosis.			Had trouble seeing/hearing		
Had a positive TB skin test			Wear contact lanes /Wear hearing aid		
Attempted suicide			Have pacemaker		
Had surgery/ what kind_____			Wear brace or implant or prosthesis		
Had nervous, Mental or Psychological Problems			Under care of other health care professionals_____		

2. **Please give statement of your present health**_____

_____

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3. **Have you ever been diagnosed or have you now having the following conditions?**

Kidney problems/ infection/stone CHECK EACH ITEM	YES	NO	DON'T KNOW	Parkinson's disease CHECK EACH ITEM	YES	NO	DON'T KNOW
Knee problems/injury/surgery				Post menopause			
Lupus				Periods of unconsciousness			
Ligament sprain/stretch/tear				Pneumonia			
Memory loss				Prostate problems			
Muscle/tendon injury/ strains				Pregnant/might be pregnant			
Multiple sclerosis				Recent Weight loss/gain			
Night sweats				Stress at home or work			
Nausea/vomiting				stroke			
Neck problems/injury/surgery				Spinal stenosis			
Numbness/tingling				Scoliosis			
Neuritis/inflammation of nerves				Spinal cord injury/compression			
Neuropathy				Tuberculosis			
Osteoporosis, Osteopenia				Tumor/growth/cyst			

4. **Please list all medications you are currently taking includes over counter, vitamin and herbal medicine.**

1.	**4.**
2.	**5.**
3.	**6.**

5. **Please list all allergies to medications, food and other substance here**_____

6. **Please list all pervious surgeries / hospitalized/Emergency room visit with reason and approximate date.**

1.
2.

7. **Other usual /current activities/ feeling.**

CHECK EACH ITEM	YES	NO	CHECK EACH ITEM	YES	NO
Smoking Cigarette			Using Oxygen for any reason		
Smoking/using other substance			Receive any shot, flu, insulin, steroid		
Drinking coffee			Feeling Hopeless. Giving up		
Drinking Alcohol			Feeling unsafe/afraid at home		

Other diagnoses, diseases, infections and conditions? Please list. _____

_____

8. **The above information provided is true and correct to the best of my knowledge and will be part of my medical record.**

_____ ____/____/____

Customer signature Date