



Confidential Health Questionnaire
 HeatherJean DeFord, MPT Physical Therapist
 Santa Cruz Integrative Medicine & Chi Center
 21511B East Cliff Drive Santa Cruz, CA 95062
 ph 831-465-9088 fax 465-8528

Name: _____ Date: _____ D.O.B.: _____
 Phone # _____ Occupation: _____
 Email: _____ Address: _____

General Health Questions

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

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

2. When was your last Medical exam? Within last month Within last 6 months More than 6 mo.
3. Have you ever been diagnosed for cancer, a tumor, or noticed any lumps or swellings? Yes No
4. Do you Smoke? Yes No
5. Do you drink alcohol (if so list # per week)? No. ___Beer. ___Wine. ___Spirits.
6. Education High School College Graduate Professional Training
7. Are you currently under the care of a physician/chiropractor/therapist/acupuncturist, counselor,... etc?
 Provider's Name & Specialty
- _____
- _____
- _____

8. Do you experience:
- Numbness/tingling/weakness in anywhere in your body
 - Urinary leaking with exercise, laughing, coughing, or on the way to the bathroom
 - Clicking, popping, or pain in your jaw

9. Have you ever been treated for any of the following: Anxiety Depression Nervous Problems
 Drug Addiction Alcoholism

10. Please list any past injuries and/or accidents (include dates if possible):

11. Have you ever seen a physical therapist before? Yes No

12. Please list all medications you are currently taking (prescription and over the counter)?

Name & Dosage	Reason for taking
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_____	_____
_____	_____
_____	_____
_____	_____

13. Daily Fluid Intake & Diet:

Indicate what amount you drink of the following in a typical day. ____ Water (8oz.) ____ Juice (8oz.)

____ Coffee (cups) ____ Tea (cups) ____ Soda (8oz.)

Do you restrict fluids? Yes No

Please describe your diet.

Allergies: medication, food or other _____

14. Bowel & Bladder Habits:

How often do you have a bowel movement? _____

Are you ever constipated? Yes No

How do you resolve this? _____

Do you experience diarrhea? Yes No

Do you use laxatives? Yes No How often/week _____

Do you use enemas? Yes No How often/week _____

Do you leak fecal matter or stain underwear? Yes No

Do you include fiber in your diet (fruit, vegetables, bran, etc.)? Yes No

Do you have a history of urine loss as a child ? Yes No

as an adolescent ? Yes No

after childbirth ? Yes No

Do you leak urine on the way to the bathroom? or when laughing?, coughing?, or exercising?

15. Gynecological History (if applicable) :

of pregnancies: ____ #of vaginal deliveries: ____ length of time pushing: _____

of episiotomies: ____ Do you have a painful episiotomy or cesaren scar ? Yes No

of C-sections: ____ Do you have a history of urinary tract infections ? Yes No

If applicable, when was your menopause onset? _____

Have you been on Hormone Replacement Therapy? Yes No Currently? Yes No

How long are your menstrual cycles? _____ How many days do you bleed? _____

How is your flow? (color and heaviness throughout) _____

If you have symptoms associated with your menstrual cycles please explain:

16. **Surgical History:** (please provide dates of all that apply to you)

_____ back/neck surgery	_____ abdominal	_____ hernias
_____ kidney surgery	_____ vaginal	_____ gall bladder surgery
_____ bladder repair	_____ ovaries removed	_____ prostate removal
_____ hysterectomy	_____ appendectomy	_____ rectal

17. **Psychosocial Status:**

Are you sexually active? _____

Is there a history of sexual trauma or sexually transmitted diseases? _____

Living arrangements: Do you live alone? Yes No

Have you had to restrict your activities due to incontinence or pain? Yes No

Have you had changes in intimate relationships/sexual functioning due to incontinence or pain? Yes No

Please list exercise, sports, hobbies or musical instruments _____

Please describe your sleeping habits (Snoring, # of hours, position, # of pillows) . _____

18. In your own words please describe your symptoms:

19. In your own words please describe what you want to achieve from physical therapy:

20. 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

How did you hear about my services? _____

Thank you for taking the time to fill out this form.