

# HEALTH INQUIRY FORM

Please complete the following information:

	____ / ____ / ____ MM / DD / YYYY
<b>Client Name</b>	<b>Date of Birth</b>

<input type="checkbox"/> Male <input type="checkbox"/> Female	Ft.      In.	Lbs.	
<b>Sex</b>	<b>Ht.</b>	<b>Wt.</b>	

**1. Have you ever been diagnosed with one of these conditions? (check all that apply)**

<input type="checkbox"/> Diabetes requiring Insulin <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Carotid Artery Disease <input type="checkbox"/> Skin Ulcers <input type="checkbox"/> Stroke or Transient Ischemic Attack (TIA) <input type="checkbox"/> Alzheimer's Disease, Lewy Body Disease, or Dementia <input type="checkbox"/> Psychosis or Schizophrenia <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS) or Myasthenia Gravis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Parkinson's Disease or Parkinsonism <input type="checkbox"/> Post-Polio Syndrome <input type="checkbox"/> Demyelinating Disease <input type="checkbox"/> Lupus (SLE) <input type="checkbox"/> Mixed Connective Tissue Disease	<input type="checkbox"/> Scleroderma <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Amputation-Due to Disease <input type="checkbox"/> Double Heart Valve Replacement <input type="checkbox"/> Organ or Bone Marrow Transplants <input type="checkbox"/> Kidney Disease or Polycystic Kidney Disease <input type="checkbox"/> Cirrhosis of the Liver <input type="checkbox"/> Hepatitis B, C, D, or E <input type="checkbox"/> Hemachromatosis <input type="checkbox"/> Metastatic Cancer <input type="checkbox"/> Multiple Myeloma <input type="checkbox"/> Brain or Spinal Cord Tumors <input type="checkbox"/> AIDS <input type="checkbox"/> Neurological Conditions affecting the brain or spinal cord <input type="checkbox"/> Muscular Conditions Causing Functional Limits
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**2. Do you have any surgeries planned or recommended?       Yes       No**

**Provide details of Type of Surgery and When is it scheduled:**

**3. Have you been hospitalized or had any ER visits in the last year?       Yes       No**

**Provide the Dates and Reasons:**

**4. Have you ever been on disability?       Yes       No**

**Provide details:**

**5. Any Special tests or x-rays scheduled?       Yes       No**

**Provide details:**

**6. Do you have a handicapped parking tag?       Yes       No**

**If yes, why?**

**7. Have you ever been turned down for any insurance coverage?       Yes       No**

**If Yes—Give Type of Insurance, Date, and Reason:**

<b>8. List all other medications you are taking</b> <input type="checkbox"/> Check here if You DO NOT TAKE ANY MEDICATIONS			
<b>Name of Medication</b>	<b>What type of MD prescribed?</b> <i>(i.e. cardiologist, oncologist etc.)</i>	<b>For What Condition</b>	<b>How long Taking</b>
<b>9. Have you been prescribed any medications you are not taking?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes—Provide Details (i.e. name of medication, who prescribed, for what condition, why not taking it):			
<b>10. When was the last time you saw your primary physician and why?</b>			
<b>Date Last Seen:</b>		<b>Reason:</b>	
<b>11. List any specialists you have seen in the last 5 years.</b>			
<b>Type of Specialist</b>	<b>Month/Year last seen</b>	<b>Reason for Visit</b>	
1.			
2.			
3.			