HEALTH HISTORY QUESTIONNAIRE
(Initial Screen)

PERSONAL INFORMATION:

Client's Name: __________________ **Age:**______ **Date of Birth:**______

Today's date: _______**Address** _________________________________
____

Email: ____

Home phone ______________________**cell phone**________________
Other____________________________

Attending Physician or other:
____

Clinic: ____________________________**Phone #**_____________________

Emergency Contact:
___________________**Phone**_____________________________

DIAGNOSIS :(Medical Condition/Injury)
____
____
____
____
____

LIST ALL SURGERIES: (Procedure and date)
____
____
____

MEDICATION: (Please list all prescription / over-the-counter)

____
____
____

Other:____
____
____
____

How did you hear about us?
____