HEALTH QUESTIONER

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| NAME: |  |

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| DO YOU CURRENTLY HAVE: | YES | NO |
| High Blood Pressure |  |  |
| Heart Disease |  |  |
| Respiratory Condition (i.e. Asthma) |  |  |
| Diabetes |  |  |
| Pacemaker |  |  |
| Epilepsy |  |  |
| Allergies or Sensitives (i.e. to heat, cold, drugs, tape…) |  |  |
| Metal Implants (i.e. pins, screws, plates, hearing aid, IUD) |  |  |
| HAVE YOU EVER HAD: | YES | NO |
| Physiotherapy |  |  |
| If yes, when? Why? | | |
| Surgery or Tumors |  |  |
| If yes, give details: | | |
| Serious Illness |  |  |
| If yes, give details: | | |
| Recent X-Ray |  |  |
| If yes, when? What body part? | | |
| ARE YOU NOW: | YES | NO |
| Pregnant |  |  |
| Receiving any other treatment (i.e. massage, acupuncture, chiro, chemotherapy, radiation, etc.) |  |  |
| If yes, give details: | | |
| Taking any medication |  |  |
| If yes, give details: | | |
| OTHER COMMENTS: | | |
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| SIGNATURE |  | DATE |  |