

BALANCED BODY

Client Health Questionnaire
Part I

Name _____ Date _____

Male () Female () D.O.B. _____ Age _____ Cultural Heritage _____

Height _____ Weight _____ Has your height or weight changed in recent months/years? _____

If you have any special needs to be considered prior to or during treatment or training, please describe below:

Overall physical condition: Poor _____ Fair _____ Good _____ Excellent _____

Major life changes in past year: (new job, baby, death in family, divorce, child leaving home, retirement)

Health habits: Exercise beyond normal daily activities and chores? No Yes Describe the exercise, including how often, how long _____

Smoker? yes no

List current medications: _____

Medical History: Check or circle those that apply to you now or in the past.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Allergies/Asthma | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Emphysema/C.O.P.D. | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Urinary/Bladder Control | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Other Lung Problems | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> GERD | <input type="checkbox"/> Back Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Essential Tremor | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Knee Problems |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Other Neurological Problems | <input type="checkbox"/> Infectious Diseases | <input type="checkbox"/> Hip Problems |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Depression | <input type="checkbox"/> TB | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Blood Clots/Phlebitis | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Broken Bone(s) |
| <input type="checkbox"/> Other Circulation Disorders | <input type="checkbox"/> Psychiatric Disorders | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Vision Disorders | <input type="checkbox"/> Other | <input type="checkbox"/> Osteopenia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing Disorders | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cancer | | <input type="checkbox"/> Skin Problems | |
- Type _____

Explain any problems you have checked above: _____

Check any current symptoms:

<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Difficulty Walking	<input type="checkbox"/> Difficulty Sleeping	<input type="checkbox"/> Joint Pain
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Cough	Where? _____
<input type="checkbox"/> Heart Palpitations	Where? _____	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Other pain?
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Weakness	<input type="checkbox"/> Difficulty Swallowing	Where? _____
<input type="checkbox"/> Ankle Swelling	<input type="checkbox"/> Arms	<input type="checkbox"/> Muscle Pain?	<input type="checkbox"/> Limited Movement
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Legs	Where? _____	Where? _____
<input type="checkbox"/> Coordination Problems	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Sprain	<input type="checkbox"/> Night Pain
<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Fever/Night Sweats	Where? _____	Where? _____

List any orthopedic (bones, tendons, ligaments, muscles, cartilage, joints) injuries or problems you have experienced for which you have had treatment, surgery, medication or physical therapy: _____

List and give approximate year of any other major illnesses, conditions, surgeries or accidents you have experienced: _____

For Women Only: Are you pregnant? _____ Date of last delivery? _____ # of pregnancies _____
of vaginal deliveries _____ # of C-sections? _____ perimenopausal? _____ menopausal? _____

Within the past year, have you had any of the following medical tests? (check all that apply)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Angiogram | <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Myelogram | <input type="checkbox"/> Bone Density Test |
| <input type="checkbox"/> MRI | <input type="checkbox"/> Pulmonary Function Tests | <input type="checkbox"/> Nerve Conduction Velocity | <input type="checkbox"/> Urine Flow Studies |
| <input type="checkbox"/> Biopsy (describe) _____ | <input type="checkbox"/> CT Scan | <input type="checkbox"/> Electromyogram | <input type="checkbox"/> Cystoscopy |
| <input type="checkbox"/> Blood Tests | <input type="checkbox"/> EKG | <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> Pap Smear |
| <input type="checkbox"/> Bone Scan | <input type="checkbox"/> Cardiac Stress Test | <input type="checkbox"/> EEG | <input type="checkbox"/> Mammogram |

If other than routine test, please explain: _____

Is there any health-related reason why you should not participate in an exercise program? _____

What would you like to get out of today's session/this program? _____

BALANCED BODY

Client Health Questionnaire
PART II

NAME: _____

What is your primary problem? _____

When/how did it begin? _____

Have you had this problem before? _____ If so, when? _____
What did you do for it? _____

Did the problem(s) get better? _____ How long did it last? _____

What treatments/diagnostic tests have you received for this problem?
 None Surgery injections Splint/Brace X-rays MRI CT Scan
 Chiropractic Care Massage Therapy Physical Therapy
 Medications (prescription and nonprescription) _____

 Other _____

How are you managing the problem now? _____

What activities are you not able to do that you could do before the problem (be as specific as you can.)
(Example: unable to reach above your head.) _____

What makes the problem worse? _____

What makes the problem better? _____

When are your symptoms most severe? AM PM Consistent all day

Since your problem began is the pain: Increased Decreased Not Changing Constant Intermittent

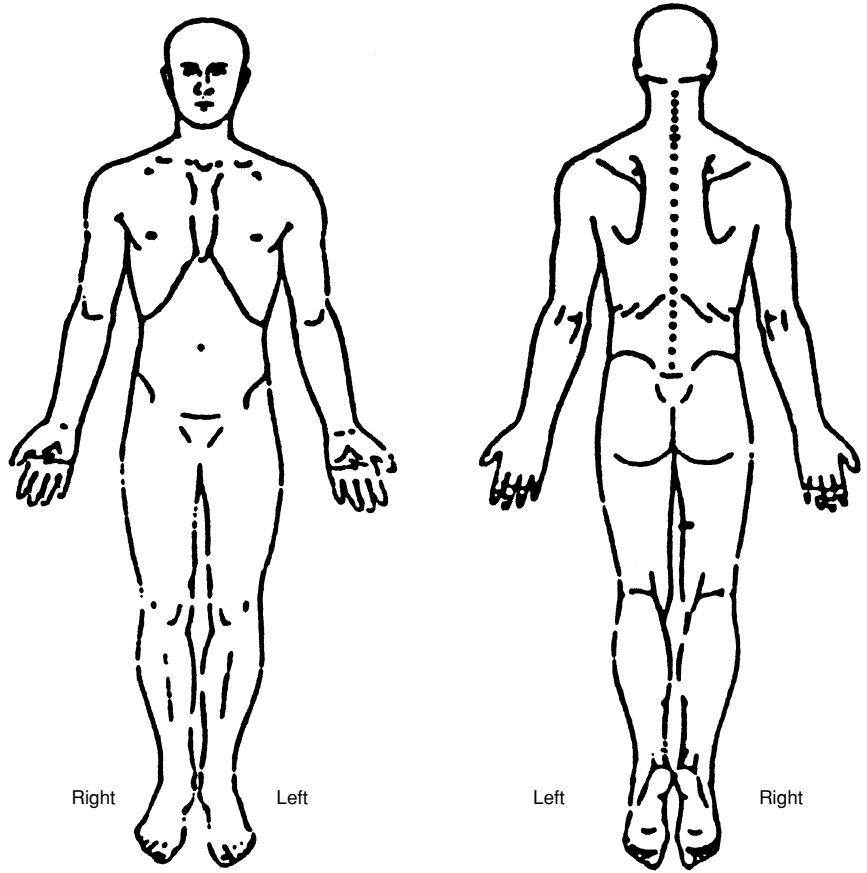
Rate your pain with 0 being no pain and 10 being the worst pain:

Pain now 0 1 2 3 4 5 6 7 8 9 10 Best day 0 1 2 3 4 5 6 7 8 9 10 Worst day 0 1 2 3 4 5 6 7 8 9 10

Do you have any other significant problems? _____

Your goal in therapy: What concerns you most? What do you hope to gain from this program?

Using the following pictures, indicate where your pain is located. Using these symbols describe your type of pain:
 Numbness === Ache ^^^ Pins/needles 0000 Stabbing ///// Burning XXXX Cramping +++++ Sharp ****



Are your symptoms affecting your ability to work or otherwise be active ____ If so, how?

Current Limitations: (check all that apply):

- Difficulty with movement
- Getting in/out of bed or up/down from a chair
- Changing positions in bed
- Difficulty with grooming and bathing
- Walking: level stairs ramps uneven terrain

Difficulty with home management (household chores, yard work, driving, shopping): _____

Difficulty with community and work activities (work, school, play, recreation): _____

Thank you for taking the time to provide this information.
 The Balanced Body Staff