

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

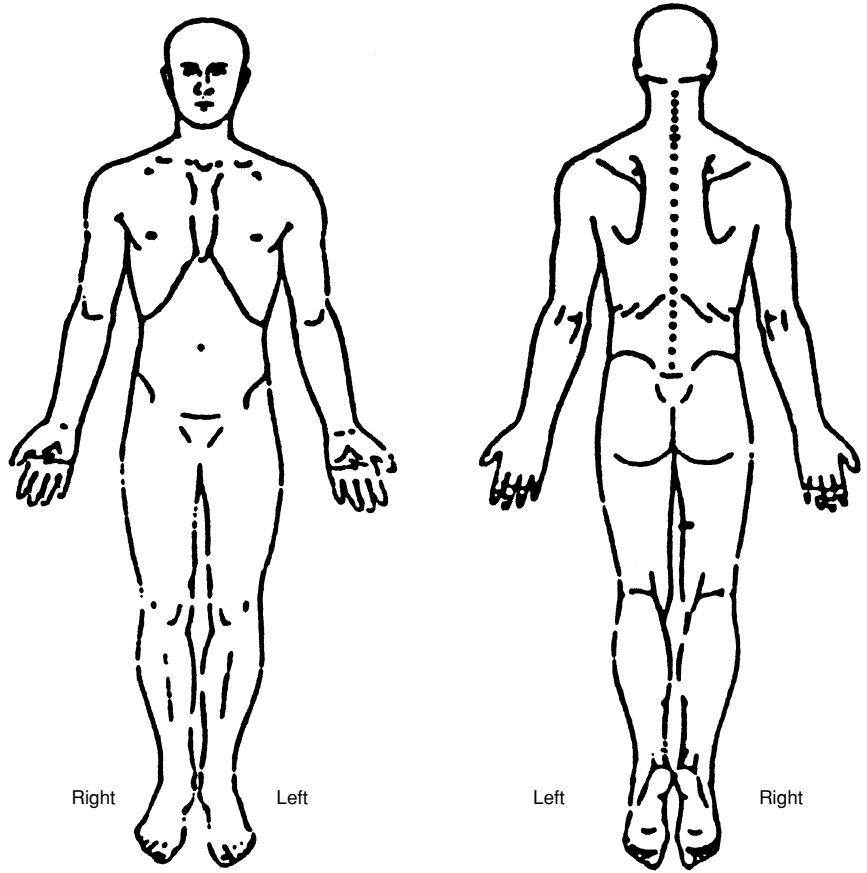
Rate your pain with 0 being no pain and 10 being the worst pain:

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?

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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): \_\_\_\_\_

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

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