HEALTH QUESTIONNAIRE

No information contained in this form is released to anyone without your written approval.

Patient Name: _____ Age: _____

Reason for this visit: _____

When did your symptoms first appear? _____ Is it getting worse? Yes No

Do the symptoms come and go or are they constant? Constant Comes and goes

On a scale from 0 - 10 (0=No Pain, 10=Severe Pain) how would you rate your pain? _____

Activities or movements that are painful to perform: Walking Sitting Bending Standing Other _____

Do your symptoms interfere with: Work Sleep Daily Routine Recreation

Are your symptoms caused by trauma (i.e. slip or fall, fall from horse, auto accident, hitting an object or an object hitting you)? Yes No If yes, please explain? _____

Have you ever had a major/severe trauma or been involved in a motor vehicle accident? Yes No

If yes, when? _____

Have you ever had this problem before? Yes No If yes when? _____ How long did it last?_____

If yes, what kind of care did you receive? _____Did it help? Yes No

Do you use tobacco products? Yes No If yes, what kind, how often and how much? _____

Do you drink alcohol? Yes No If yes, what kind, how often and how much? _____

What is (if retired What was) your occupation? _____

How long have/had you been in this occupation? _____

In the last **10 years** have you had: **(Circle all that apply.)**

Musculo-Skeletal	**Respiratory/Sinus**	**GI (Stomach/Gut)**	**Organ Systems**	**Cardiac**
Multiple Sclerosis	Chronic Bronchitis	Celiac Disease	Kidney Disease	Pacemaker
Polio	Asthma	Leaky Gut	Lack of Bladder Control	Irregular Heartbeat
Arthritis	Earaches	Chronic Constipation	Painful Urination	Pain in Legs on Exertion
Gout	Ringing in Ears	Chronic Diarrhea	Blood in Urine	Heart Disease
Fractures	Whooping Cough	Bowel Changes	Excessive Thirst	High Cholesterol
Osteoporosis	Nosebleeds	Excessive Gas	Diabetes	High/Low Blood Pressure
Numbness	Persistent Cough	Indigestion/Heartburn	Prostate Problems	Dizziness
Swelling in Ankles	Pneumonia	Food Sensitivities	Erectile Dysfunction	Fainting
Varicose Veins	Allergies	Offensive Bowel Odor	Hepatitis	Stroke
Hernia	**Infectious Diseases**	Weight Loss/Gain	Fatty Liver	Headache in the Morning
Fibromyalgia	Hepatitis	Rectal Bleeding	Depression	**Other**
Blood Disorders	Rheumatic Fever	Vomiting Blood	Difficulty Sleeping	Tumors or Growths
Anemia	Tuberculosis	Ulcers	Tiredness	Cancer
Bleeding Disorders	Scarlet Fever		TMJ/Dental Problems	Fibroids
Bruise Easily	Yeast Infections	Thyroid Dysfunction	Double Vision	Breast Lump
HIV +	Vaginal Infections	Adrenal Dysfunction	Blurred Vision	Miscarriages
Leukemia	Herpes/Cold Sores	Chronic Fatgue	Migraine Headaches	Pregnancies

List Medications you Currently Take:

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Have you ever had any surgeries, medical problems or conditions not listed above? If yes, please list.

I certify that the above information is correct to the best of my knowledge. I will not hold Red Hawk Healthcare, Cross Roads Wellness, Dr. D'Amanda or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ Date: _____