lift
BIOMECHANICS

Optimal Form, Optimal Function
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HEALTH HISTORY QUESTIONNAIRE

Confidentiality

The information you provide here may be discussed *only* with your referring practitioner, unless you indicate otherwise.

-If Pamela Rief may NOT consult with your referring practitioner, please check here: □

-If Pamela Rief may NOT consult with your family member(s), please check here: □

If you do not wish to fill out this Health History Questionnaire, please discuss with Pamela Rief.

Basic Personal Information

Name: _____ Date: _____
Birthdate: _____ Age: _____
Gender Identity: _____ Height _____ Shoe size: _____

Priorities

Please list the challenges with which you would like help. How long ago did each begin?

1._____

2._____

3._____

4._____

5._____

Comfort Assessment

Are you comfortable when using your home furniture? □ No □ Yes If not, please explain:
_____

Are you comfortable when using office furniture? □ No □ Yes If not, please explain:
_____

Are you comfortable when in car/on bus/subway/train? □ No □ Yes If not, please explain:
_____

Are you comfortable in all of your clothing? □ No □ Yes If not, please explain:
_____

Are you comfortable in all of your shoes? □ No □ Yes If not, please explain:
_____

What material are your floors at home? (check all that apply):
□ Wood □ Carpeting □ Linoleum □ Ceramic/Stone/Porcelain □ Other _____

What materials are *underneath* your floors at home? (check all that apply):
□ Concrete □ Wood □ Other _____

Body Shape Satisfaction

Are you satisfied with the shape/strength of your back? □ No □ Yes If not, please explain:
_____

Are you satisfied with the shape/strength of your chest/shoulders? □ No □ Yes If not, please explain: _____

Are you satisfied with the shape/strength of your abdomen? □ No □ Yes If not, please explain: _____

Are you satisfied with the shape/strength of your buttocks? □ No □ Yes If not, please explain: _____

Are you satisfied with the shape/strength of your feet? □ No □ Yes If not, please explain (*e.g.,* flat feet, toes smooshed together, *etc*. _____

Health Parameters

Please check if you have had (in the past two years):
□ Poor balance
□ Muscle weakness
□ Areas of numbness
□ Muscle pain
□ Knee pain, or past knee injuries or surgeries
□ Sinus problems
□ Facial pain and/or eye pain
□ Neck pain or tension
□ Shoulder pain
□ Back pain
□ Back tightness
□ Hip pain (front, side, or back of hips?)
□ Buttock pain (muscle tightness or anal pain?)
□ Foot/ankle pain
□ Hand/wrist pain
□ Frequent urination
□ Wake during the night to urinate
□ Unable to hold urine when laughing, sneezing, lifting, dancing, other
□ Impotency/erectile dysfunction
□ Sudden energy drop (what time of day?)

□ Chronic Fatigue
□ Intolerance to cold (hands, feet, and/or general?)
□ Grinding teeth
□ Jaw clicks/jaw pain
□ Ear pain or ringing in the ears
□ Headaches and/or migraine headaches
□ Talking is tiresome (*e.g.,* on the phone, while walking, when projecting voice in public speaking)
□ Dry mouth upon waking or other times of day
□ Snoring
□ Difficulty falling asleep, or staying asleep as long as desired
□ Rapid heart rate with physical activity
□ Mild anxiety to high anxiety
□ Depression, *e.g.,* due to physical limitations, seasonal factors, *etc.*
□ Other physical or performance impediments you'd like to eradicate (please describe):

_____
_____

Significant Trauma

If they may have worsened/caused your condition(s), please list surgeries, falls, fractures, auto accidents, other accidents, other injuries, repetitive strain (from work, playing an instrument, sports, technology-use); include emotional trauma; and dates:

_____
_____
_____
_____

Relevant Prior Treatments

Healthcare Provider	Dates	Diagnosis/Treatment	Treatment Effectiveness
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Additional Aspects of Functional Health

Please circle the activities below that can be uncomfortable, challenging, breathless, or painful:

Sit on chair, sit on floor, get up with ease from sitting on chair or floor, spend a full day at the office, stand for long durations, bend, walk for long distances, run, sleep, sneeze, cough, breathe deep, laugh, climb stairs, hike uphill, descend stairs, hike downhill, compute, use phone, get up from a chair, put on/tie shoes, get in/out of car/SUV, sit in a car/bus/subway/train, stand in subway/bus, lift light objects, carry bags/briefcase/backpack/ purse, lift heavy objects, job-related duties, enjoy hobbies, shop, read, socialize, entertain, participate in athletic activities (please list below).

List any other challenging desired or necessary activities:

_____
_____
_____

Health Maintenance & Lifestyle

Sufficient and regular sleep at least 5 of each 7 nights? □ No □ Yes If no, please explain:

_____

Do you wake "restored" when you have sufficient sleep? □ No □ Yes If no, please explain:

_____

Satisfied with your diet? □ No □ Yes If no, please explain:

_____

Stretching? □ No □ Yes If yes, please describe type/frequency:

_____

Hobbies/recreation? □No □Yes If yes, please describe activities/frequency:

_____

Physical activity? □No □Yes If yes, please describe activities/frequency:

_____

Relaxation? □ No □ Yes If yes, please describe activities/frequency:

_____

Frequent computer use? □ No □ Yes If yes, please describe technologies/frequency:

_____

Frequent driving? □ No □ Yes If yes, please describe frequency:

_____

Do you have any other concerns or needs that you wish our work will address?

_____
_____
_____
_____

Additional Personal Information

Home Address _____

Home Phone _____ Cell Phone _____

Email Address _____

Emergency Contact (name and cell phone number) _____

Who referred you to my services? _____

What kind of work do you do? (If you are no longer working, what kind of work did you do before, or do you wish to pursue?)_____

_____

Signature of Client/Parent/Guardian: _____ **Date:** _____

If signed by client representative, please state relationship to client: _____