lift
BIOMECHANICS

Optimal Form, Optimal Function

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HEALTH HISTORY QUESTIONNAIRE

Confidentiality

Unless you prefer total confidentiality, the information you provide here may be discussed *only* with your referring practitioner/family member(s).

-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 during or prior to your appointment.

Basic Personal Information

Name: _____ Date: _____
Birthdate: _____ Age: _____
Gender: □ Male □ Female 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 satisfied with comfort using your home furniture? □ No □ Yes If not, please explain:

_____
_____

Are you satisfied with comfort while using office furniture? □ No □ Yes If not, please explain:

_____
_____

Are you satisfied with comfort in your car? □ No □ Yes If not, please explain:

_____
_____

Are you satisfied with comfort in all of your clothing? □ No □ Yes If not, please explain:

_____
_____

Are you satisfied with comfort in all of your shoes? □ No □ Yes If not, please explain:

_____

_____

Body Shape Satisfaction Please complete this section if it is relevant to your priorities:

Are you satisfied with shape of back? □ No □ Yes If not, please explain:

_____

_____

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

_____

_____

Are you satisfied with shape of abdomen? □ No □ Yes If not, please explain:

_____

_____

Are you satisfied with shape of buttocks? □ No □ Yes If not, please explain:

_____

_____

Are you satisfied with shape of feet? □ No □ Yes If not, please explain (*e.g.,* flat feet, toes smooshed together, corns, calluses, etc):

_____

_____

Health Parameters Please check if you have had (in the past six months):

□ Poor balance
□ Grinding teeth
□ Jaw clicks
□ Ear pain or ringing in the ears
□ Headaches and/or Migraine headaches (where and when?)
□ Sinus problems
□ Facial pain and/or eye pain
□ Neck Pain
□ Other head or neck problems?
□ Muscle pain
□ Knee pain
□ Back Pain
□ Shoulder pain
□ Foot/ankle pain
□ Hand/wrist pain
□ Hip pain
□ Muscle weakness
□ Other joint, bone or muscle problem
□ Areas of numbness
□ Frequent urination
□ Do you wake to urinate?
□ Unable to hold urine when laughing, sneezing, lifting, dancing, other
□ Impotency
□ Sudden energy drop (what time of day?)
□ Intolerance to cold (hands, and/or feet, or general?)

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 list the activities below that you are unable to do *comfortably, free of pain*:

Sit on chair, sit on floor, get up from sitting on chair or floor, stand for short or long durations, bend, walk for short or long distances, sleep, 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, travel in a car, lift light objects, lift heavy objects, job-related duties, enjoy hobbies, shop, read, socialize, entertain, participate in athletic activities (list) or other desired/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/needs not listed above that you would like addressed?:

_____

_____

_____

_____

_____

Additional Personal Information

Street Address _____

City _____ State _____ Zip Code_____

Home Phone _____

Cell Phone _____

Email Address _____

Marital Status _____

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: _____