Healthy Connection Physical Medicine

DR. VIDA I PUODZIUNAS

Health Questionnaire

Name: _____Age____ Home Phone #: _____ Work Phone #: _____

Address: _____City: _____ State ____Zip: _____

Occupation: _____# Hours/Week Currently Working:_____

E-mail Address: _____Cell Phone #: _____

Check off any of the following symptoms you have experienced in the past 6 months:

☐ Low Back Pain
☐ Pain between Shoulder Blades
☐ Neck Pain
☐ Tension/Headaches
☐ Fibromyalgia
☐ Tension Across Top of Shoulders
☐ Numbness/Tingling in Arms/Hands
☐ Numbness/Tingling in Legs/Feet
☐ Pain in the legs
☐ Pain in the feet
☐ Tired/Fatigued
☐ Difficulty Sleeping
☐ Allergies
☐ Digestive Problems
☐ Carpal Tunnel
☐ Weight Loss: _____ lbs

OTHER (explain) _____

Which of the above is the worst? _____

How long have you had it? _____

How often does it occur? _____

What does it feel like ?(describe) _____

What have you done that has helped this problem? _____

What activities would you like to do if this was not a problem? _____

Does this cause you to be:
☐ Moody
☐ Irritable
☐ Interrupt sleep
☐ Restricted in your daily activities

Does this affect your work:
☐ Decision making
☐ Poor attitude
☐ Decreased productivity
☐ Exhausted at the end of the day
☐ Unable to work long hours

Does this affect your life:
☐ Lose patience with spouse/children
☐ Restricted household duties
☐ Hinders ability to exercise or sports
☐ Interferes with ability to do hobbies or other activities

What have you tried to help relieve/get rid of this problem and how much did it help? (circle appropriately)
◆ Medications…Helped: Little Some Much
◆ Physical Therapy…Helped: Little Some Much
◆ Chiropractic…Helped: Little Some Much
◆ Exercise…Helped: Little Some Much
◆ Nutrition…Helped: Little Some Much
◆ Stretching…Helped: Little Some Much

OTHER _____

Insurance:
☐ PPO ☐ HMO ☐ Medicare ☐ Other ☐ None

Is condition due to accident? ☐ Yes ☐ No Date_____
Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

There are several alternatives available to you. Please check the item most appropriate for you

☐ I would like to come to the Doctor's office for a complete evaluation. This will allow me to find out if I can be helped without any financial barriers

☐ I would like the Doctor to call me to discuss my health problems before making an appointment