Ascent Therapy Clinics
HEALTH QUESTIONAIRE

In order to provide you with the very best care, we would like to know some things about you.

Name ________________________________ Date ____________________

Age: ________ Height ____________ Weight ____________

Are you pregnant? Y/N Due Date __________ OB-GYN _______________________

Area of the body we are treating: Low Back/Mid Back/Neck
Hip/Knee/Ankle
Shoulder/Elbow/Hand/Wrist

Other: ____

Did you have an accident? Y/N Auto/Work Date of Accident: ________________

Do you NOW or have you EVER had any of the following medical conditions?

Y/N Asthma
Y/N High Blood Pressure
Y/N Diabetes
Y/N Emphysema
Y/N Immuno-Suppressed
Y/N Artificial Joint, where?
Y/N Arthritis (Rheumatoid/Osteo)
Y/N Cancer, type________
Y/N Ulcers
Y/N Stroke
Y/N Psychiatric Care
Y/N Blood Disorder
Y/N Epilepsy
Y/N Fainting
Y/N Heart Disease
Y/N Allergies
Y/N Pacemaker
Other:________________
____

Medications you are currently taking: ____
____

Do you smoke or use tobacco products? Y/N

Occupation: ____

Desk Job? Y/N Prolonged Sitting/Standing? Y/N Lifting? Y/N

How would you rate your pain on a scale of 0 - 10? (0 = No Pain, 10 = Severe Pain)

0 1 2 3 4 5 6 7 8 9 10 Please draw your area of pain below:

____
Signature of Person Completing Form