



General Health Questionnaire

Eastside Sports Rehabilitation Clinic

Patient: _____ Age: _____

Diagnosis or Problem Area: _____

Please complete this questionnaire so that we are able to provide you the best possible care. Check any problems below that you have now and/or have had trouble with in the past.

- | | |
|---|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Bleeding/Bruising Easily |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Numbness to Hands and Feet | <input type="checkbox"/> Skin Rash/Disease |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Severe Night Pain |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Difficulty with Balance | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Frequent Falls | <input type="checkbox"/> Bladder Problems |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Surgery Please list: |
| <input type="checkbox"/> Other Orthopedic Injuries | _____ |

Do you smoke? _____

Do you exercise? _____ If so, how often? _____

Do you get short of breath with exertion (up/down stairs)? _____

Women, is there any chance of pregnancy? _____

Please list any medications you are taking: _____

On a scale of 1-10 with 1 being the least or no pain and 10 being extreme pain, what would you rate your injury/problem area when it acts up? _____

List some activities that seem to aggravate your injury/problem area _____

List some activities that seem to relieve your injury/problem area _____

Do you have any other special problems/concerns we should know about?

Patient Signature

Parent / Guardian Signature

Date