Pinnacle Therapy Centers
1738 Elton Road, Suite 303, Silver Spring, Maryland 20903
Tel: 301-439-8000 Fax: 301-439-5030

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):			?M ☐F	**DOB: / /**
Medical Doctor Name:	**Address:**	**Phone #:**	**Date of last physical exam:**	

PERSONAL HISTORY

List any traumas, fractures, accidents, injuries, or falls, including auto accidents. Provide date	
List any medical problems that other doctors have diagnosed, surgeries, or hospitalizations	
List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers	
List any sports that you played in the past or currently play	

Check if you have/have had any symptoms in the following areas to a significant degree/briefly explain.		
??Headaches	??Mid Back Pain	??Ringing in the ears
??Neck Pain	??Mid Back Stiffness	??Frequent Sinus Infections
??Neck Stiffness	??Low Back Pain	??Constipation/Poor Digestion
??Shoulder Pain/Stiffness	??Low Back Stiffness	??Frequent Urination
??Arm Pain	??Leg Pain	??Dizziness
??Arm Tingling/Numbness	??Leg Tingling/Numbness	??Asthma
??Wrist Pain/Weakness	??Ankle Pain/Weakness	??Cancer
??Hand Pain/Stiffness	??Foot Pain/Stiffness	??Diabetes
??Muscle Soreness	??Muscle Spasms	??Arthritis
? HIV/AIDS	??MEN: Prostate Problems	??WOMEN: Menstrual Problems
Woman Only:		
First day of last menstrual period?	Are you pregnant? ? yes ☐ no	If yes, Due date:
Nursing? ? yes ☐ no	Taking birth control pills/ patch? ? yes ☐ no	Date of last pregnancy?
Recent changes in:		
??Weight	??Mood	??Flexibility
??Energy level	??Ability to sleep	??Other pain/discomfort

FAMILY HISTORY
List any medical problems that your parents, grandparents, siblings, aunts/uncles, or children suffer from or take medication for

TODAY'S COMPLAINT	
Why are you here?	
Have you had this/these problems before? ??Yes ☐ No	
If yes, When:	
When did the problem(s) begin?	
How did the problem(s) begin?	
Have you seen anyone else for this/these condition(s)? ??Yes ☐ No	If yes, What treatment was provided?
	What were the results?
What aggravates this/these condition(s)?	
Are your symptoms getting worse? ??Yes ☐ No	
What makes the condition better?	

HEALTH HABITS AND PERSONAL SAFETY ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.	
Exercise	??Sedentary (No exercise) ??Mild exercise (climb stairs, walk 3 blocks, golf) ??Occasional Vigorous Exercise (less than 4x/week for 30 minutes) ??Regular vigorous exercise (4x/week for 30 minutes)
Diet	Are you dieting? ☐ Yes ☐ No If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No

Caffeine	? None	??Coffee	??Tea	??Cola
	# OF CUPS/ CANS PER DAY?			
Alcohol	Do you drink alcohol? ☐ Yes ☐ No Are you concerned about the amount you drink? ☐ Yes ☐ No			
	Do you drive after drinking? ☐ Yes ☐ No			
Tobacco	Do you use tobacco? ☐ Yes ☐ No			
	Cigarettes pks./day:_____ Chew - #/day:_____ Other:_____			
	# of years:_____ Or year quit:_____			
Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? ☐ Yes ☐ No				
Patient Name:				Date