FUSIONPHYSIO | **Health Questionnaire**

This is a questionnaire regarding your general medical health status. Please fill out as concisely as possible.

Do you have any life threatening allergies? Yes ☐ No ☐ If **Yes**, please note:					
Have you been diagnosed with or do you have any of the following?					
Heart Condition:	Yes ☐	No ☐	Chronic Lung Condition	Yes ☐	No ☐
High Blood Pressure: - When last checked? (>2 yrs-get cked)	Yes ☐	No ☐	Diabetes:	Yes ☐	No ☐
			Arthritis:	Yes ☐	No ☐
Stroke:	Yes ☐	No ☐	Cancer:	Yes ☐	No ☐
High Cholesterol:	Yes ☐	No ☐	Epilepsy:	Yes ☐	No ☐
Pace Maker:	Yes ☐	No ☐	Tuberculosis:	Yes ☐	No ☐
Asthma:	Yes ☐	No ☐	HIV/AIDS:	Yes ☐	No ☐
Head Injury:	Yes ☐	No ☐	Hepatitis: A ☐ B ☐ C ☐	Yes ☐	No ☐
Headaches:	Yes ☐	No ☐	Circulatory Condition:	Yes ☐	No ☐
Seizures:	Yes ☐	No ☐	Kidney Condition:	Yes ☐	No ☐
Fibromyalgia/Chronic Fatigue Syndrome:	Yes ☐	No ☐	Osteoporosis:	Yes ☐	No ☐
			Steel Pins:	Yes ☐	No ☐
Have you been exposed to a contagious infection? (ie. lice, scabies, rubella (German measles)? If **Yes**, please explain and state how long ago:				Yes ☐	No ☐
Are you pregnant?	Yes ☐	No ☐			
Are you presently taking any medications (prescription or otherwise)? If **Yes**, please list (including dosage):				Yes ☐	No ☐
Have you been in hospital for any major surgery or illness?				Yes ☐	No ☐
Have you had any motor vehicle accidents?				Yes ☐	No ☐
Do you feel pain in your chest when you do physical activity?				Yes ☐	No ☐
In the past month, have you had chest pain when you were not doing physical activity?				Yes ☐	No ☐
Do you lose your balance because of dizziness or do you ever lose consciousness?				Yes ☐	No ☐
Do you have a bone or joint problem (other than your present injury) that could be made worse by a change in your physical activity?				Yes ☐	No ☐
Do you know of any other reason why you should not do physical activity?				Yes ☐	No ☐
Have you been, or are you being, treated by any other health care worker regarding the area you are having treated today? (ie. Chiropractor or Massage Therapy): If **Yes**, when? What type of treatment?				Yes ☐	No ☐
Have you had any of the following tests with respect to your current illness/injury?:					
X-rays:	Yes ☐ No ☐		Bone Scans:	Yes ☐	No ☐
CT Scan:	Yes ☐ No ☐		Bone Density:	Yes ☐	No ☐
MRI:	Yes ☐ No ☐		Other:		
Do you have any other tests/surgery scheduled? If **Yes**, please specify:	Yes ☐	No ☐			

Name: ______________________________ Date: ______________________