Client General Health Questionnaire

Name:_____ Date of Birth:_____

Date: _____ Age:_____

Marital Status: _____

Reason for Visit: _____

The Following questions will be help the health care professionals have an in-depth idea of your general health and habits, to help treat you as a patient to the best of their abilities.

Questionnaire

1. Do you have any preexisting illnesses or health concerns that maybe contagious to those around you? If so, please give further details below. Yes No

_____

_____

_____

2. Are you on any form of treatment or medication for a preexisting health concern or allergies? If so, please list all medications below. Yes No

_____

_____

_____

3. Have you ever broken/ fractured any bones? Yes No
   If yes, what was the level of pain?
   A. Little to no pain
   B. Uncomfortable
   C. Moderate
   D. Very painful
   E. Excruciating pain
4. **True of False**: You smoke / drink alcohol (circle those that apply if true).
5. How often do you use the drug on a scale from 1- 5? (1 being rarely and 5 being habitually) _____