

Carnahan Therapy Patient Health Questionnaire

Health History

(Federal regulations require a medical history to be included in all patients' medical records)

Do you now have or have you had any of the following:

Arthritis:

- Osteoarthritis
- Rheumatoid
- Osteoporosis**
- Asthma**
- COPD**
- (circle)* **Emphysema or Bronchitis**

Heart/ Cardiovascular:

- CHF Pacemaker
- Angina
- Heart attack
- Peripheral vascular disease
- High blood pressure
- (circle)* **Stroke or TIA**

Neurological Disease:

- Multiple sclerosis
- Parkinson's
- Neuropathies**
- Cerebellar problems (Ataxia)**
- Brain injury**
- (circle)* **Epilepsy or Seizures**
- Headaches**

Allergies

- Diabetes:** *(circle)* Type I or II
- Hiatal Hernia**
- (circle)* **Kidney, Bladder or Prostate problems**
- Incontinence**

Gastrointestinal Disease:

- (circle)* Ulcer Reflux Bowel
- Liver Gall bladder
- Cancer**
- Hepatitis**
- AIDS**
- Hearing impairments**
- Inner ear problems**

Visual Impairments:

- Glaucoma
- Cataracts
- Macular degeneration
- Thyroid**

Spine Pain:

- Neck
- Thoracic
- Low Back
- Spinal Stenosis
- Degenerative disc disease
- Sleep dysfunction**
- (circle)* **Prosthesis or Implants**
- Previous accidents**
- Reaction to Heat**
- Reaction to Cold**
- Anxiety**
- Panic disorder**
- Depression**
- Addictions**
- Change in appetite**
- Weight gain**
- Weight loss**
- Prior surgery** *(list details below in "Surgical*

List your current prescribed medications: (or provide us with a list)

Type	Mg	Frequency	Type	Mg	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

List surgical history with approximate dates: _____

What type of long term exercise program would you be interested in when you complete therapy:

Home program only _____ **Gym program** _____ **F.I.T. program** _____ **Other** _____

Patient signature

Date