HEALTH HISTORY – QUESTIONNAIRE I | Page 1

Name: _____ Date: _____
First Last D.M.Y

The following characteristics might relate to your conditions. Please check the corresponding boxes if you are troubled by those or if you ever had those characteristics.

General

- ○ Allergies / Food Intolerances
- ○ Alcoholism / Drug Abuse
- ○ Diabetes
- ○ Poor Sleep
- ○ Obesity
- ○ Excessive Thirst
- ○ Fatigue / Brain Fog
- ○ Lack of Concentration
- ○ Thyroid Disease
- ○ Adrenal Disease
- ○ Cancer
- ○ Abnormal Weight Loss / Gain
- ○ Fever / Chills (without Flu)
- ○ Throat Soreness

Family History

Parents, Grandparents, Siblings

- ○ Diabetes
- ○ Cancer
- ○ Kidney Disease
- ○ Liver Disease
- ○ High Blood Pressure
- ○ High Cholesterol Levels
- ○ Heart Disease
- ○ Muscle, Bone, Nerve Disease
- ○ Rheumatoid Arthritis
- ○ Stroke
- ○ Thyroid Disease

Musculoskeletal

- ○ Scoliosis
- ○ Osteoporosis
- ○ Mb. Bechterew
- ○ Mb. Schlatter
- ○ Neck Pain
- ○ Lower Back Pain
- ○ Foot / Ankle Pain
- ○ Knee / Hip Pain
- ○ Rheumatoid Arthritis
- ○ Hand / Wrist Pain
- ○ Elbow / Shoulder Pain

Eye, Ear, Nose, Throat

- ○ TMJ
- ○ Sinusitis
- ○ Tonsil Problems
- ○ Eye Pain (around, in, behind)
- ○ Visual Impairments
- ○ Nose Bleeds
- ○ Ear Noises / Ringing
- ○ Dental Problems
- ○ Tooth Implants / Crones
- ○ Deafness / Difficulty Hearing

Neurological

- ○ Headache / Migraine
  - ○ last occurred:_____
- ○ Fainting
- ○ Dizziness
- ○ Mental Disorders
- ○ Tingling / Numbness
- ○ Tremors / Epilepsy / Twitching
- ○ Weakness

Genitourinary

- ○ Painful Urination
- ○ Kidney Disease / Stones
- ○ Blood in Urine
- ○ Strongly Coloured Urine
- ○ Difficulty Starting Flow
- ○ Inability to control Flow
- ○ Frequent Urination
- ○ Frequent Night Urination
- ○ Sexual Difficulties
- ○ Urinary Tract Infection

Gastrointestinal

- ○ Hernia
- ○ Appendicitis
- ○ Constipation
- ○ Diarrhea
- ○ Hemorrhoids
- ○ Gas / Belching
- ○ Black / Bloody Stools
- ○ Abdominal Pain
- ○ Liver Problems
- ○ Nausea / Vomiting
- ○ Gallbladder Problems
- ○ Poor Appetite
- ○ Poor Digestion
- ○ Ulcer / Heartburn
- ○ Stomach Problems

Cardio-Respiratory

- ○ Stroke
- ○ Heart Problems
- ○ High Blood Pressure
- ○ Rheumatic Fever
- ○ Varicose Veins
- ○ Difficulty Breathing
- ○ Chronic Cough
- ○ Chest Pain
- ○ Asthma / COPD
- ○ Arteriosclerosis
- ○ Tuberculosis
- ○ Lower Leg / Ankle Swelling
- ○ Hand Swelling

Men Only

- ○ Prostate Problems
- ○ Testicular Swelling / Pain

Woman Only

- ○ Excessive Flow
- ○ Cycles Irregularities
- ○ Hot Flashes
- ○ PMS
- ○ Pregnancy of Births: ____
- ○ Vaginal Burning / Itching
- ○ Painful Periods
- ○ Endometriosis
- ○ Date last Period began:_____

Name: _____ Date: _____
First Last D.M.Y

Have you had any surgeries? Y / N Please name below, including complications and date:

_____

_____

_____

Have you had any injuries in the past? Y / N Including bicycle/traffic/sports injuries, falls, with date:

_____

_____

_____

Please score and describe what's been the most stress for you lately? Including physical & mental stress

Score: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

_____

_____

Please describe any serious conditions or diseases you have or had (even if listed in the boxes), including when it occurred, treatment and current state:

_____

_____

_____

_____

How many hours do you spend sitting a day (24 hours)? Including commuting, leisure, occupation:

Hours: ○ 0-4 ○ 5-6 ○ 7-8 ○ 9-10 ○ 11-12 ○ 12+

I have completed this form to the best of my ability and discussed the information with Movewell professionals. I understand that they rely upon this information to make treatment recommendations.

_____ _____

Patient Signature
(If the patient is not yet 18 years old, a parent must sign.)

Movewell® – Martin Strietzel