

Health History – QUESTIONNAIRE I | Page 1



Name: _____
First Last

Date: _____
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