JUPITER MEDICAL CENTER

WELLNESS SERVICES

Health History Questionnaire

Name_____ Date _____

Address _____ Occupation _____

City_____ Zip_____ JMC employee_____ Auxiliary_____

Home Phone _____ Work Number_____

Emergency Contact_____ Birthdate____/____/_____ Male __ Female ___

Address _____ Relationship _____ Phone # _____

Primary Care Physician _____ Primary Care Physician Phone _____

How did you hear about our program(s)? friend ___ physician___ newspaper___ other (explain) _____

Please answer the following, as they apply to you, by checking the appropriate box:

(Y=Yes N=No)

Y	N	
		Heart attack - date _____
		Physician diagnosed heart trouble
		* irregular heart beat
		* heart murmur
		* heart valve problems
		* rheumatic heart disease
		* angina
		Stroke- date_____
		COPD- emphysema,
		Diabetes - is it controlled?_____
		Cancer - under current treatment
		Bone/Joint/Fracture disorder
		High Cholesterol level_____
		date tested_____
		Pregnant: Due date_____
		Hypertension - Is it controlled _____

Y	N	
		Anemia
		Arthritis
		Back pain
		Bursitis
		Chronic recurrent cough
		Gout
		Hernia
		Phlebitis
		Epilepsy
		Low blood pressure (ie 90/50)
		Fibromyalgia
		Osteoporosis
		Have you ever smoke? How long_____
		Do you presently smoke. How much_____
		Other: _____

FAMILY HISTORY

Please check the appropriate boxes if any of YOUR IMMEDIATE BLOOD FAMILY
MEMBERS have had or currently have the following conditions:

___ Heart attack ___ Angina ___ Heart failure ___ Angioplasty

___ Heart surgery ___ Vascular disease ___ Stroke ___ High cholesterol

PERSONAL HISTORY (SURGERY)

Please check the appropriate boxes if you have had the following surgeries .

___ Back surgery / date_____ ____ Heart surgery / date_____

___ Joint surgery / date_____ Other_____

Have you ever participated in any rehab programs? Cardiac ____Physical Therapy ____Pulmonary____
If you checked one, where_____

Please list any medication/supplements that you are currently taking (name and reason):

_____

_____

_____

Please list any food or drug allergies:_____

MENTAL HEALTH HISTORY

Have you sought or are you currently under treatment/ counseling from a psychotherapist/ psychiatrist? _____

If yes, when, why, for how long?_____

ACTIVITY STATUS

Do you engage in a structured exercise program? Yes ___ No ___

If yes, # days a week____ # of minutes a day _____

My exercise includes:_____

PERSONAL HEALTH GOALS

Consider your own health goals and check the box next to the goals that are important to you.

- ☐ Improve strength
- ☐ Improve flexibility
- ☐ Improve cardiovascular fitness
- ☐ Improve muscle tone and shape
- ☐ Lose weight/inches *(circle one or both)*
- ☐ Improve diet/eating habits
- ☐ Gain weight/muscle
- ☐ Reduce stress
- ☐ Stop smoking/drinking
- ☐ Injury prevention
- ☐ Continue to rehabilitate injury
- ☐ Increase energy

If your concern is **osteoporosis:**

Do you take hormone replacements?_____ If yes, what kind, and how much_____

Date of onset of menopause?_____Any history of fractures?_____

Any family history of osteoporosis?_____ If yes, what family member and what age_____

Would you like to be on our mailing list? If so, check here _____

We would like you to complete our information before seeing the provider. If the client is a minor the information must be completed by a parent or guardian. We are committed to providing the best care possible to our client and we charge what is usual and customary for the services rendered. You are responsible for payment in full at the time of service. We accept cash, checks, and all major credit cards. **WE DO NOT FILE ANY INSURANCE.**

Please refrain from wearing scents or perfumes to respect the needs of all clients.

I HAVE READ THE ABOVE POLICY. I UNDERSTAND AND AGREE TO ALL OF ITS TERMS. I HEREBY AUTHORIZE THE PROVIDER(S) OF THE WELLNESS SERVICES OF JUPITER MEDICAL CENTER TO PERFORM TREATMENT AND RECORD REVIEW WHICH WILL BE DISCUSSED WITH ME AS THEY DEEM APPROPRIATE.

_____ _____

Signature Date

Comments: