Colorado Spine Therapy Medical Screening Questionnaire

Name:_____

Do you smoke? __Yes __No

Do you have a pacemaker? __Yes __No

Are you currently pregnant or do you think you might be pregnant? __Yes __No __NA

Have you been or are you on long term steroid use? __Yes __ No / Height ____ weight ____

Do you or have you had any facial / jaw pain? __Yes __No

Have you recently noticed any of the following?

__ Fatigue
__ fever/chills/sweats
__ nausea/vomiting
__ weight loss/gain
__ balance issues
__ falls
__ night pain
__ numbness/tingling
__ muscle weakness
__ dizziness/light headedness
__ heartburn/indigestion
__ difficulty swallowing
__ changes in bowl/bladder function
__ difficulties sleeping
__ constipation
__ diarrhea
__ shortness of breath
__ fainting
__ cough
__ headaches
__ unexplained weight loss

Have you EVER been diagnosed with any of the following conditions?

__ (skin) cancer
__ heart problems
__ chest pain/angina
__ high blood pressure
__ circulation problems
__ blood clots
__ stroke
__ anemia
__ bone or joint infection
__ chemical dependency
__ depression
__ lung problems
__ tuberculosis
__ asthma
__ rheumatoid arthritis
__ other arthritic conditions
__ bladder/urinary tract infection
__ kidney problem/infection
__ sexually transmitted disease/HIV
__ pelvic inflammatory disease
__ thyroid problems
__ diabetes
__ osteoporosis
__ multiple sclerosis
__ epilepsy
__ ulcers
__ liver problems
__ hepatitis
__ pneumonia

Has anyone in your immediate family EVER been diagnosed with any of the following conditions?

__ cancer
__ heart problems
__ high blood pressure
__ gout
__ diabetes
__ stroke
__ depression
__ tuberculosis
__ thryroid problems
__ blood clots

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches)

_____
_____

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

_____
_____