



WELLSPRING THERAPY, INC.

The source for healing

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Health History Questionnaire

Name _____

Date _____

To help us with your therapy, please indicate whether you have experienced any medical problems related to the following:

- | | Yes | No | | Yes | No |
|-----------------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|
| • Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> | • Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| • Arrhythmia | <input type="checkbox"/> | <input type="checkbox"/> | • Dizziness | <input type="checkbox"/> | <input type="checkbox"/> |
| • Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | • Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| • High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | • Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| • Stroke | <input type="checkbox"/> | <input type="checkbox"/> | • Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| • Short of Breath | <input type="checkbox"/> | <input type="checkbox"/> | • Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| • Smoking | <input type="checkbox"/> | <input type="checkbox"/> | • Headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| • Chronic Cough | <input type="checkbox"/> | <input type="checkbox"/> | • Current Pregnant | <input type="checkbox"/> | <input type="checkbox"/> |
| • Hepatitis/HIV Positive/TB | <input type="checkbox"/> | <input type="checkbox"/> | • Loss of Sensation | <input type="checkbox"/> | <input type="checkbox"/> |

Other Illnesses: _____

Surgery History: _____

Metal Implants in Body: _____

Medications: _____

Pain: Your pain is: Constant Intermittent

On a scale of 0-10, (0—no pain, 10-- most painful), your pain is _____

Location of your pain: _____

Prior Therapy: Yes____ No____ If yes, was it helpful? _____

Sports & Activities (bowling, golf, jogging, etc): _____

Previous episode of this problem? ____ Yes ____ No If yes, please describe: _____

Primary Physician: _____ Phone Number: _____