WORKPLACE SOLUTIONS

HEALTH SCREEN

Name:		Date:	MM/DD/YYYY	☐ Female ☐ Male
Date of Birth:	MM/DD/YYYY	Date of Injury:	MM/DD/YYYY ☐N/A	

Please answer the following questions (your responses will be kept completely confidential)

1	Has your doctor ever said you have heart trouble?	☐ YES ☐ NO	6	Do you experience difficulty breathing when resting?	☐ YES ☐ NO
2	Do you frequently have pains in your heart or chest ?	☐ YES ☐ NO	7	Do you have a history of asthma, emphysema or COPD?	☐ YES ☐ NO
3	Do you ever feel faint or have spells of severe dizziness?	☐ YES ☐ NO	8	Do you have a persistent cough?	☐ YES ☐ NO
4	Have you ever had a seizure?	☐ YES ☐ NO	9	Have you had a recent viral infection?	☐ YES ☐ NO
5	Have you ever been told that your blood pressure is too high?	☐ YES ☐ NO	10	Have you had any surgery in the past twelve (12) months?	☐ YES ☐ NO
11	Do you have any problems with swelling in your legs or feet?				☐ YES ☐ NO
12	Are you currently on any medication?				☐ YES ☐ NO

List all the PRESCRIBED medications you are taking	Dosage	Prescribing physician	Prescribing physician's phone number

List all the over-the-counter (non-prescribed) medications you are taking	Dosage	List all the herbal/homeopathic/naturopathic products you are taking	Dosage

13	Is there any medication you are supposed to be taking that you are not taking ?	☐ YES ☐ NO	16	Have you ever been diagnosed with depression or anxiety?	☐ YES ☐ NO
14	If female, are you pregnant ?	☐ YES ☐ NO	17	Has stress negatively affected your work-life balance in the past 6 months ? (for example, time off work or illness)	☐ YES ☐ NO
15	Is there a good physical reason, not mentioned here, why you should NOT follow an activity/exercise program ?	☐ YES ☐ NO	18	Have you experienced a significant weight loss or gain in the past 60 days ?	☐ YES ☐ NO

Please indicate if you have any of the following:

19	Diabetes ?	☐ YES ☐ NO	25	Current fatigue or nausea ?	☐ YES ☐ NO
20	Metal pins, plates, or screws inserted into a bone ?	☐ YES ☐ NO	26	Blackouts ?	☐ YES ☐ NO
21	Bowel problems ?	☐ YES ☐ NO	27	Circulation problems ?	☐ YES ☐ NO
22	Bladder problems?	☐ YES ☐ NO	28	Cancer (past or present) ?	☐ YES ☐ NO
23	Rheumatoid arthritis ?	☐ YES ☐ NO	29	Pace maker ?	☐ YES ☐ NO
24	Epilepsy ?	☐ YES ☐ NO	30	Blood clots ?	☐ YES ☐ NO
			31	Osteoporosis ?	☐ YES ☐ NO
32	Any other condition(s) not listed ? ☐ YES ☐ NO	If Yes, please provide details:			
33	33. Do you have any allergies ? ☐ YES ☐ NO	If Yes, please provide details:			

Emergency Contact:		Emergency Phone:		In case of a medical emergency, do you have any special instructions for your therapist? ☐ YES ☐ NO
If Yes:				

It is very important that you have provided accurate responses to this Health questionnaire. Knowingly withholding and/or providing inaccurate medical information can have serious consequences, and can compromise any treatment and/or work recommendations from CBI Workplace Solutions. To the best of my knowledge, I certify that the given information is accurate and complete.	_____ **Client Signature** _____ **Date:**

FOR OFFICE USE ONLY				
Resting heart rate			Blood pressure	
Follow up with physician if necessary:	Therapist name:		Date of call:	
Physician comments:				