FYZICAL®
Dizziness & Fall Prevention Centers

Client Name: _____

Date: _____

Case #: _____

Client Health Questionnaire

1. Have you had a fall in the past year?	☐ Yes ☐ No
2. Do you have a fear of falling?	☐ Yes ☐ No
3. Would you like your balance to be assessed?	☐ Yes ☐ No
4. Do you experience dizziness or imbalance?	☐ Yes ☐ No
5. Do you lose your balance when stepping up/down curbs or stairs/steps	☐ Yes ☐ No
6. Do you have a difficult time walking in the dark?	☐ Yes ☐ No
7. Do you have difficulty hearing?	☐ Yes ☐ No

8. Do you have osteoporosis, osteoarthritis and/or joint pain?	☐ Yes ☐ No
9. Do you take bone and/or joint supplements?	☐ Yes ☐ No
10. Do you experience muscle aches, pains and/or muscle cramping?	☐ Yes ☐ No
11. Do you use cold, heat or compression therapy at home?	☐ Yes ☐ No
12. Are you interested in learning how compression clothing with ice could help your condition?	☐ Yes ☐ No
13. Are you interested in learning how home heat and/or cold therapy could help your condition?	☐ Yes ☐ No

14. Do you have foot and/or ankle pain/discomfort?	☐ Yes ☐ No
15. Do you currently wear shoe inserts?	☐ Yes ☐ No
16. Are you interested in learning about how a shoe insert could help your condition?	☐ Yes ☐ No
17. Do you have pain and/or physical challenges other than what you are being seen for today?	☐ Yes ☐ No
18. Would you like to get more information about your whole body health?	☐ Yes ☐ No
19. Are you interested in learning how a medically based fitness program could safely optimize your physical condition?	☐ Yes ☐ No