

California Functional Capacity Protocol Health Questionnaire

Evaluated: _____ Date: _____

Directions: If you can answer YES to the question asked, put a circle around the YES.
If you have to answer NO to the question asked, put a circle around the NO.
Answer all questions. If you are not sure, guess.

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|-----|---|-----|----|
| 1. | Do you need glasses to read? | YES | NO |
| 2. | Do you need glasses to see things at a distance? | YES | NO |
| 3. | Do you wear contact lenses? | YES | NO |
| 4. | Are you hard of hearing? | YES | NO |
| 5. | Do you wear a hearing aid? | YES | NO |
| 6. | Do you suffer from asthma? | YES | NO |
| 7. | Are you troubled by constant coughing? | YES | NO |
| 8. | Have you ever coughed up any blood? | YES | NO |
| 9. | Do you sometimes have severe soaking seats at night? | YES | NO |
| 10. | Do you suffer from angina (heart pain in the chest or arm)? | YES | NO |
| 11. | Have you ever had a heart attack? | YES | NO |
| 12. | Does heart trouble run in your family? | YES | NO |
| 13. | Have you ever had an electrocardiogram? | YES | NO |
| 14. | Have you ever had a stress (exercise tolerance) test? | YES | NO |
| 15. | Do you wake up at night short of breath | YES | NO |
| 16. | Has a doctor ever said you blood pressure was too high or low? | YES | NO |
| 17. | Have you ever been told of high blood cholesterol? | YES | NO |
| 18. | Do you have pains in the heart or chest? | YES | NO |
| 19. | Does your heart often race like mad? | YES | NO |
| 20. | Do you find it hard to breathe? | YES | NO |
| 21. | Do you get out of breath long before anyone else? | YES | NO |
| 22. | Do you suffer from swollen ankles? | YES | NO |
| 23. | Have you ever taken water pills? | YES | NO |
| 24. | Have you ever been told of a heart murmur? | YES | NO |
| 25. | Have you ever been told of a problem with your heart valves? | YES | NO |
| 26. | Have you recently gained weight? | YES | NO |
| 27. | Have you recently lost weight? | YES | NO |
| 28. | Have you ever had any surgery? | YES | NO |
| 29. | Have you ever had any broken bones? | YES | NO |
| 30. | Do you suffer from weak or brittle bones? | YES | NO |
| 31. | Do you use aspirin, Tylenol® or ibuprofen regularly? | YES | NO |
| 32. | Do your muscles or joints often feel stiff? | YES | NO |
| 33. | Do you often have severe pains in the arms or legs? | YES | NO |
| 34. | Do you have weak or painful feet? | YES | NO |
| 35. | Do pains in the back make it hard for you to keep up your work? | YES | NO |
| 36. | Are you troubled with a serious bodily disability or deformity? | YES | NO |
| 37. | Do you have any chronic skin conditions? | YES | NO |
| 38. | Do you suffer from frequent headaches? | YES | NO |
| 39. | Do you often have pressure or pain in the head? | YES | NO |
| 40. | Do you often have spells of dizziness? | YES | NO |

41.	Do you often feel faint?	YES	NO
42.	Have you fainted more than twice in your life?	YES	NO
43.	Do you often have numbness or tingling in any part of your body?	YES	NO
44.	Was any part of your body ever paralyzed?	YES	NO
45.	Were you ever knocked unconscious?	YES	NO
46.	Did you ever have a fit or convulsion (epilepsy)?	YES	NO
47.	Has a doctor ever said you had a hernia (rupture)?	YES	NO
48.	Do you often get spells of complete exhaustion or fatigue?	YES	NO
49.	Does working tire you out completely?	YES	NO
50.	Does every little effort wear you out?	YES	NO
51.	Are you constantly too tired and exhausted even to eat?	YES	NO
52.	Are you frequently confined to bed by illness?	YES	NO
53.	Are you always in poor health?	YES	NO
54.	Do severe pains and aches make it impossible for you to do your work?	YES	NO
55.	Do you suffer from any chronic disease?	YES	NO
56.	Are you definitely <i>under</i> weight?	YES	NO
57.	Are you definitely <i>over</i> weight?	YES	NO
58.	Have you ever had a serious injury?	YES	NO
59.	Do you suffer from diabetes?	YES	NO
60.	Do you usually have great difficulty in falling asleep or staying asleep?	YES	NO
61.	Do you smoke more than 20 cigarettes a day?	YES	NO
62.	Do you drink more than six cups of coffee or tea a day?	YES	NO
63.	Do you usually take two or more alcoholic drinks a day?	YES	NO
64.	Have you ever taken non-prescription drugs?	YES	NO
65.	Do you frequently use over-the-counter medicines?	YES	NO
66.	Do you use sleeping pills?	YES	NO
67.	Do you use vitamins regularly?	YES	NO
68.	Do you take iron pills regularly?	YES	NO
69.	Have you ever needed the services of a chiropractor?	YES	NO
70.	Do you regularly take tranquilizers or sedatives?	YES	NO
71.	Do you usually feel unhappy and depressed?	YES	NO
72.	Do you often cry?	YES	NO
73.	Are you always miserable and blue?	YES	NO
74.	Does life look entirely hopeless?	YES	NO
75.	Do you often wish you were dead and away from it all?	YES	NO
76.	Does worrying continually get you down?	YES	NO
77.	Does every little thing get on your nerves and wear you out?	YES	NO
78.	Are you easily upset or irritated?	YES	NO
79.	Are there any medications you are supposed to take that you are not taking?	YES	NO

Reviewed by: _____

Date: _____