HEALTH QUESTIONNAIRE

DATE_____

NAME_____ AGE_____ BIRTHDATE___/___/____

Hand dominance: right □ left □ ambidextrous □

Work status: Full time □ Part time □ Not working □

Any Current Restrictions from your doctor:_____

MEDICAL HISTORY:

Known allergies (latex, nickel, other):_____

Are you pregnant or attempting pregnancy? YES ☐ NO ☐ Yes number of weeks pregnant _____

Do you or have you ever smoked? YES ☐ NO ☐ If so, how much and when _____

Do you consume alcohol? YES ☐ NO ☐ If so, how much and how often _____

Have you had any surgeries/previous injuries that required medical care? _____

_____

_____

PLEASE CHECK AND SELECT APPROPRIATE ANSWERS

Do you have a history of :	YES	NO	COMMENTS
Anemia or chronic fatigue	☐	☐	_____
Autoimmune disease (arthritis, gout, lupus)	☐	☐	_____
Cancer	☐	☐	_____
Chest pain/heart disease	☐	☐	_____
Circulation problems, blood clots, varicose veins	☐	☐	_____
Brain/spinal cord injuries (including epilepsy)	☐	☐	_____
Peripheral nervous system injuries (carpal tunnel/sciatica)	☐	☐	_____
Birth defects	☐	☐	_____
Diabetes or hypoglycemia	☐	☐	_____
Steroid or cortisone use (prescribed/non-prescribed	☐	☐	_____
Hearing, vision, other sensory problems	☐	☐	_____
Transmittable diseases (hepatitis, HIV/AIDS)	☐	☐	_____
High blood pressure or stroke history	☐	☐	_____
Liver, kidney disease and/or stones	☐	☐	_____
Loss of bladder or bowel control	☐	☐	_____
Lung disease or asthma	☐	☐	_____
Osteoporosis or other bone problems	☐	☐	_____
Phobias, sleep disorder, depression, psych. disorders	☐	☐	_____
Polio	☐	☐	_____
Poor wound healing, bruising, bleeding disorders	☐	☐	_____

Rheumatic or scarlet fever	☐	☐	_____
Ulcers or stomach problems	☐	☐	_____
Thyroid conditions	☐	☐	_____

Additional comments:

Current Condition or diagnosis: _____

Describe the injury or condition for which physical therapy is being prescribed:
_____
_____
_____

Date of Injury or onset of symptoms:_____/_____/_____

Have you experienced similar symptoms before?_____

Have you had surgery for this condition?_____ Date of surgery _____/_____/_____

What medical treatment have you received for your condition?_____
_____

Have any of the above treatments been successful? _____

Check all that describe your pain:
Burning □ Sharp □ Aching □ Tingling □ Throbbing □ Numbness □ Other_____

Rate your pain level on a scale of 1-10 (1= minor, 10 = emergency level) _____

Is the pain constant or intermittent?_____

When is your pain the worst: (check all that apply) Morning □ Daytime □ Evening □ Nighttime □

What makes your pain better?_____

Worse?_____

Has your condition improved, stayed the same, or worsened since the onset?_____

What test have you had for this condition? X-rays □ MRI □ CAT Scan □ EMG □ Other □

Test results _____

Current medications (inc. prescriptions, over the counter, or supplements) _____
_____

What activities would you like to return to?