plan physical therapy_____

injury . recovery . connected

Health History Questionnaire

First Name: _____MI: _____ Last Name: _____

DOB:_____ Height:_____ Weight:_____ Occupation: _____ Gender: M / F

SYMPTOMS: ❑ Pain ❑ Balance
❑ Weakness ❑ Other:_____

Date Symptoms Started: _____/ _____/_____ ❑ Don't remember

CAUSED BY: ❑ Injury ❑ Accident
❑ Surgery ❑ Other:_____

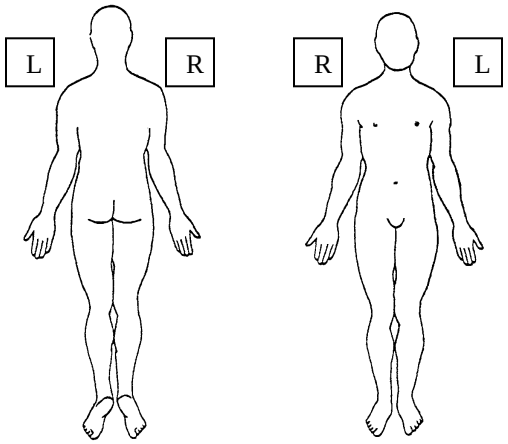
MEDICATIONS (check all that apply):

❑ Pain pills ❑ Anti-inflammatory medication ❑ Muscle relaxants
❑ Antidepressants ❑ Blood thinners * Please provide copy of medication list

Allergies: _____

BODY CHART:

On the chart to the right, please mark the areas where you feel symptoms.



Current pain: _____(0-10)

Lowest Pain Level: _____(0-10)

Highest Pain Level:_____(0-10)

DIAGNOSTIC TESTS:

❑ None ❑ X-ray ❑ MRI ❑ CAT Scan ❑ Ultrasound

OTHER TREATMENT (for these symptoms):

❑ Physical therapy ❑ Chiropractic care ❑ Acupuncture

SYMPTOMS in the last month (check all that apply):

❑ Shortness of breath ❑ Recurring Headaches ❑ Falls
❑ Increased Pain at night ❑ Bowel or Bladder Problems ❑ Nausea

CONDITIONS (check all that apply):

❑ Cancer ❑ Rheumatoid arthritis ❑ Osteoporosis
❑ Heart disease / condition ❑ Blood Clots ❑ Pacemaker
❑ Circulation problems ❑ Diabetes

Current smoker ❑ yes ❑ no ***past*** smoker ❑ yes ❑ no ***currently*** pregnant ❑ yes ❑ no

GOAL FOR THERAPY:_____

Patient/Guardian Signature:_____ Date: _____

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