Health History Questionnaire

What condition are you seeking treatment for?___________________

Date of Injury for this condition?_____________________

Date of Surgery for this condition?____________________

Have you ever had Physical Therapy before? Yes No

Have you ever had Physical Therapy for this condition? Yes No If yes, when_________

Have you had other treatments for this condition? Yes No   If yes, what type__________

Do you have a metal implanted in you body? Yes No If yes, where________________

Do you have a pacemaker? Yes No

Are you or might you be pregnant? Yes No

Are you taking any medication? Yes No If yes, what___________________________

Have you had Home Healthcare? Yes No If yes, when___________________________

Have you ever had: (Please circle what applies)

Heart trouble

Circulatory problems

Nerve/Sensation problems

Dizzy spells

High Blood Pressure

Trouble with your vision

Trouble with your hearing

Other serious illness, what_____________

In general would you say your health is:

Excellent Very Good Good Fair Poor

You have answered the above questions the best to your ability.

Patient Signature___________________________________

Date_______________________________________