



Patient Medical History

The purpose of this questionnaire is to help us understand your health status. Please complete this form and your therapist will answer any questions during your initial assessment examination. This form is considered part of your medical record.

Patient Name: _____ **DOB:** _____

1	When was your last general health check up?			Date:
2	Have you ever been told that you have:			Therapist Comments:
	High Blood Pressure	Yes	No	
	Heart Problems	Yes	No	
	Lung Problems	Yes	No	
	Kidney Problems	Yes	No	
	Head Injury	Yes	No	
	Stroke/Neurological Problems	Yes	No	
	Liver Problems	Yes	No	
	Thyroid Problems	Yes	No	
	Blood Disorders	Yes	No	
	Diabetes (High Blood Sugar)	Yes	No	
	Low Blood Sugar	Yes	No	
	Past Fractures/Dislocations	Yes	No	
	Asthma	Yes	No	
	Seizure	Yes	No	
	Cancer	Yes	No	
	Arthritis	Yes	No	
	Shingles	Yes	No	
	Ringing Ears	Yes	No	
	Tuberculosis or Hepatitis	Yes	No	
	Repeated Infections	Yes	No	
	Depression	Yes	No	
	Osteoporosis	Yes	No	
	Circulation/Vascular Problems	Yes	No	
	Ulcer/Stomach Problems	Yes	No	
3	For Men Only:			
	Prostate Disease	Yes	No	
4	For Women Only:			
	Pelvic Inflammatory Disease	Yes	No	
	Endometriosis	Yes	No	
	Are you Pregnant?	Yes	No	

<< See Reverse Side >>



5	Have you recently had:			
	Unexplained Weight Loss/Gain	Yes	No	
	Loss of Appetite	Yes	No	
	Unexplained Fever or Chills	Yes	No	
	Unremitting Night Pain	Yes	No	
	Joint Pain or Swelling	Yes	No	
	Urinary or Bowel Problems	Yes	No	
	Fatigue/Malaise/Tiredness	Yes	No	
	Numbness or Tingling	Yes	No	
	Weakness in the Arms or Legs	Yes	No	
	Recent Falls or Loss of Balance	Yes	No	
	Coordination Problems	Yes	No	
	Difficulty Walking	Yes	No	
	Dizziness or Loss of Consciousness	Yes	No	
	Chest Pain	Yes	No	
	Heart Palpitations	Yes	No	
	Shortness of Breath	Yes	No	
	Difficulty Swallowing	Yes	No	
	New Onset of Headaches	Yes	No	
	Visual Problems	Yes	No	
	Hearing Problems	Yes	No	
	Hoarseness	Yes	No	
	Cough	Yes	No	
6	Do you smoke?	Yes	No	If yes, how many? Packs/Day
7	List Any Hospitalizations/Surgeries:			
8	List Any Other Medical Problems:			
9	List Any Allergies:			
10	List Your Current Medications: _____ _____ _____			
11	Have you had a bone density test?	Yes	No	
12	Do you feel your overall health is: (Check one) ___ Excellent ___ Good ___ Fair ___ Poor			
13	Reviewed By: _____			
I certify that the above information is accurate to the best of my knowledge:				
Signature: _____ Date: _____				