Medical History Questionnaire

Patient Name:_____ DOB:_____/_____/_____

Height: _____ Pt Weight: _____ SSN:_____-_____-_____ Hand Dominance: ○Right Hand ○Left Hand

Work Status: _____ Employer:_____ Job Title:_____ Restricted Duty?_____

Email: _____ Cell Number: _____ Home Number: _____

Home Address: _____

Primary Doctor: _____ Group:_____ Specialist:_____ Group:_____

Primary Insurance: _____ Secondary Insurance: _____ **OR** Attorney: _____

Do you have any customs, religious beliefs, or wishes that may affect care? _____

Medical History: Please Check if Have/Had any of the following:

☐ Alzheimers	☐ Broken Bones	☐ Ulcers/GI Conditions	☐Heart Conditions	☐Type 1 Diabetes
☐ Parkinsons	☐ Osteoporosis	☐Seizures/Epilepsy	☐High Blood Pressure	☐Type 2 Diabetes
☐ Lupus	☐ Obesity	☐ Rheumatoid Arthritis	☐Blood Disorders	☐Current Infection
☐ Cancer	☐ Fibromyalgia	☐Autoimmune Disease	☐Stroke	☐Other:

Have you ever had surgery: ○Yes ○No If yes, please describe and include the dates:

_____ Date: _____

_____ Date: _____

_____ Date: _____

Please Rate your Health: ○Good ○Fair ○Poor ○Other:_____

Do you exercise beyond normal daily activities and chores? ○Yes ○No If yes, describe the exercise:_____

Describe the problem(s) for which you are seeking physical therapy for: _____

_____

When did the current problem(s) begin? _____ Have you previously experienced this? ○Yes ○No

Have you received Physical therapy at all in the past 12 months? ○Yes ○No If yes, for what: _____

Please list any and all medications you are currently taking both prescription and over the Counter:_____

_____

To stay within the compliance guidelines of HIPAA, please list any person(s) below that you authorize us to disclose information regarding your protected health information, including your billing information. (You do not need to list doctors)

_____

Patient Signature: _____