THE PHYSICAL THERAPY CENTER

Medical History Questionnaire

Patient Name:	Date of Birth:	Age:
Reason for Therapy:	Date of Injury/Onset:	
Have you had surgery for this condition? Yes No		
Are you currently receiving any other care for the condition mentioned above? Yes No		
Have you had x-rays, MRI? Yes No Results?		
Have you ever received therapy in the past for the condition mentioned above? Yes No		
Previous treatment received:		
Have you received therapy services for other problems/conditions this year?		
Height Weight	Could you be pregnant?	Yes No

Do you now or have you ever had any of the following problems? Please circle					
Arthritis	Yes	No	Fractures	Yes	No
Osteoporosis	Yes	No	Cancer/Tumor	Yes	No
High Blood Pressure	Yes	No	Recent weight gain/loss	Yes	No
Heart Disease	Yes	No	Current Infection(s)	Yes	No
Heart Attack	Yes	No	Tuberculosis	Yes	No
Pacemaker	Yes	No	Hepatitis	Yes	No
Vascular Disease	Yes	No	Thyroid Problems	Yes	No
Stroke	Yes	No	Headaches	Yes	No
Asthma	Yes	No	Head Injury/Concussion	Yes	No
Shortness of Breath	Yes	No	Hernia	Yes	No
Chronic Cough	Yes	No	Kidney/Bladder	Yes	No
Fainting Spells	Yes	No	Surgeries	Yes	No
Diabetes	Yes	No	Hearing Loss	Yes	No
Anemia	Yes	No	Depression	Yes	No
Swelling in Ankles	Yes	No	Anxiety	Yes	No
Deep Vein Thrombosis	Yes	No	Substance Abuse	Yes	No
Seizures/Epilepsy	Yes	No	Sexual Abuse	Yes	No
Metal in Body/Surgical Implant	Yes	No	Other	Yes	No

If you answered "yes" on any of the above, please explain and give approximate dates:
Do you have any allergies? Yes No If yes, list:
Are you presently taking any medications? Yes No If yes, list:
At the present time, would you say that your health is (circle one):
Excellent Very Good Fair Poor

The information is correct to the best of my knowledge.

X	Date:

Patient/Parent/Guardian Signature