

Patient Name: _____

Date of Birth: _____

Phone Number: _____

Health Questionnaire

What is the reason your doctor has referred you? _____

Describe your current symptoms _____

Duration of current symptoms _____

Have you received any diagnostic testing for this current condition: **Yes** **No**

What type of testing have you received? X-RAY CT SCAN PET MRI BONE SCAN EMG

Where was the test performed? _____ When? _____

Describe to the best of your knowledge the results of the testing: _____

Are you being hurt or made to feel afraid? Yes NO _____

Please X next to any condition listed below that you currently have or may have had

High Blood Pressure	Diabetes	Bowel/Bladder Incontinence
Heart Attack	Frequent Urination	Painful Urination
Chest Pain	Excessive Thirst	Stress Incontinence
Stroke		
Angina	Impaired Vision	
Pacemaker	Impaired Hearing	Parkinson's
	Dizziness/falls	Polio
Respiratory Problems		Post Polio
Asthma	History of Cancer	Multiple Sclerosis
Shortness of Breath	Radiation	
Lung Disease	Chemotherapy	Depression
Smoking	Tumor	Mental Illness
Persistent Cough		
	Difficulty Swallowing	Fibromyalgia
Rheumatoid Arthritis	Heart burn/Reflux	Chronic Pain
Lupus		Headaches/Inc. Freq.
Scleroderma	Arthritis	
Reynaud's	Osteoporosis	Abnormal Weight gain/loss
	Osteopenia	General Fatigue
Thyroid	Joint pain/stiffness	
MRSA	Pregnant	
C-Diff	Menopause	

*****Have you received any therapy services this calendar year? Yes No**

Circle which services(s) PT OT ST Date: _____

Have you received any therapy services for this current condition: Yes No Date: _____

Patient/Guardian Signature: _____ Date: _____

Patient Name:

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PROBLEM LIST

Medical Problems

Surgeon _____ Proc. _____

Date	Problem	Date	Problem

Surgical Procedures/Hospitalizations

Date	Surgery	Date	Surgery

Medications

Medication	Dose/Frequency	D/C	Date	Medication	Dose/Frequency	D/C	Date

Allergies

Latex: Yes No

Medication/Allergen	Reaction

