GOOD HEALTH
PHYSICAL THERAPY & WELLNESS

Medical History Questionnaire

Last Name: _____ First Name: _____ M.I.: _____ Goes By: _____

Date of Birth: _____/_____/_____Sex designated on Insurance: _____Pronouns(he/she/they/other) _____

Mailing Address:_____

Phone: _____Email Address: _____

Does our office have permission to leave a detailed message on your voicemail? ◯ **YES** ◯ **NO**

Allow mass emails for marketing purposes (i.e. exercise classes, owner's new book coming out, etc)**:** ◯ **YES** ◯ **NO**
(if NO, you will still receive emails regarding pertinent clinic information such as inclement weather closures)

I would like my billing statements emailed instead of sent through USPS mail: ◯ **YES** ◯ **NO**

I authorize automatic credit card charges for any statement balances and/or unpaid balances: ◯ **YES** ◯ **NO**
(if YES, please fill out the corresponding Credit Card Authorization form)

Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Other Spouse/Partner Name: _____

Work Status: ◯ Employed ◯ FT Student ◯ PT Student ◯ N/A Employer: _____

How did you hear about us? _____

I would like to receive appointment confirmations by: ◯ Email ◯ Text ◯ Both

Emergency Contact

Last Name: _____ First Name: _____ Relationship:_____

Phone:_____ **Do we have permission to discuss medical information with them?** ◯ **Yes** ◯ **No**

Referring Provider: _____ Primary Care Physician: _____

What brings you in for physical therapy? _____

Have you had surgery for this ailment? ◯ Yes ◯ No Type(s) and Date(s) of Surgery: _____

Rate your pain on a scale of 1 to 10 **(1 being no pain, 10 being maximum pain tolerable)**: At Rest ____ At Worst ____ At Best ____

My pain can be described as **(please check all that apply)**:

☐ Constant ☐ Intermittent ☐ Sharp ☐ Dull ☐ Aching ☐ Stabbing ☐ Numbness ☐ Pins/Needles

What makes your pain better/worse? _____

Have you had any of the following care for **THIS** injury/episode? **(please check all that apply)**

☐ Chiropractor	☐ Massage Therapy	☐ EMG/NCV	☐ Emergency Room Care	☐ CT Scan
☐ General Practitioner	☐ Neurologist	☐ MRI	☐ Podiatrist	☐ Myelogram
☐ Occupational Therapy	☐ Orthopedist	☐ X-Rays	☐ Naturopath	☐ Physical Therapy

Patient Goals: What do you expect to get from treatment? _____

Have you had an injury due to a fall in the past year? ◯Yes ◯No Have you had 2+ falls in the last year? ◯Yes ◯No

Have you received physical, occupation, or speech therapy, or chiropractic services at any other office this injury? ◯Yes ◯No

Prescription and non-prescription medications, vitamins, or herbal medications

Name: _____ Dose: _____ Frequency: _____ Reason: _____

Name: _____ Dose: _____ Frequency: _____ Reason: _____

Name: _____ Dose: _____ Frequency: _____ Reason: _____

Date of last General Health Check-Up: _____ **Height:** _____ **Weight:** _____

Surgical/Trauma History: Please list type of surgery/trauma/accident, and month/year it occurred:

_____

_____

Do you now have, or have you ever had, any of the following? (C = Current, P = Past)

C	P		C	P		C	P	
☐	☐	Allergies	☐	☐	Incontinence/Bowel Problems	☐	☐	Ehlers-Danlos Syndrome
☐	☐	Anemia	☐	☐	Kidney Problems	☐	☐	Chronic Fatigue Syndrome
☐	☐	Anxiety	☐	☐	Metal Implants	☐	☐	Head/Neck Injury
☐	☐	Arthritis/Swollen Joints	☐	☐	MRSA	☐	☐	Back Injury
☐	☐	Asthma	☐	☐	Multiple Sclerosis	☐	☐	Shoulder Injury
☐	☐	AutoImmune Disorder	☐	☐	Muscular Disease	☐	☐	Elbow Injury
☐	☐	Cancer/Chemotherapy/ Radiation	☐	☐	Osteoporosis	☐	☐	Wrist/Hand Injury
			☐	☐	Parkinson's	☐	☐	Hip/Leg injury
☐	☐	Cardiac Conditions	☐	☐	Rheumatoid Arthritis	☐	☐	Knee Injury
☐	☐	Cardiac Pacemaker	☐	☐	Seizures/Epilepsy	☐	☐	Ankle/Foot Injury
☐	☐	Chemical Dependency	◯Yes ◯No		**Do You Smoke?**	☐	☐	Recreational Drug Use
☐	☐	Circulation Problems	☐	☐	Speech Problems	☐	☐	Mental Health Treatment
☐	☐	Depression	☐	☐	Strokes/TIA	◯Yes ◯No		**Latex/Tape Sensitivity**
☐	☐	Diabetes	☐	☐	Thyroid Disease/Goiter			
☐	☐	Dizzy Spells/Fainting	☐	☐	Tuberculosis			**IF RELEVANT:**
☐	☐	Emphysema/Bronchitis	☐	☐	Vision problems	☐	☐	Pelvic Inflammatory Disease
☐	☐	Fibromyalgia	☐	☐	Hernia	☐	☐	Irregular Menstrual Cycle
☐	☐	Fractures	☐	☐	Infectious Disease	☐	☐	Endometriosis
☐	☐	Gallbladder Problems	☐	☐	Gout	#_____		Complicated Pregnancies
☐	☐	Frequent Headaches	☐	☐	Reiter's Syndrome	#_____		Complicated Deliveries
☐	☐	Hearing Impairment	☐	☐	Sleeping Difficulty	#_____		C-Section Deliveries
☐	☐	Hepatitis	☐	☐	Numbness or Tingling	#_____		Vaginal Deliveries
☐	☐	High Cholesterol	☐	☐	Weakness	◯Yes ◯No		**Are you Pregnant?**
☐	☐	High/Low Blood Pressure	☐	☐	Weight Gain/Loss			
☐	☐	HIV/AIDS	☐	☐	Energy Loss			

Please list any other conditions you have, or have ever had that are not listed above that you feel could be important to your care:

_____

_____

Patient/Guardian Signature: _____ **Date:** _____