

Supplemental Medical History Questionnaire

Patient	Name:		Pronouns (he/she/they/other):					
	nass emails for marketing you will still receive emails					_	-	NO
I would like my billing statements emailed instead of				f sent through USPS mail:				NO
I authorize automatic credit card charges for any stat (if YES, please fill out the corresponding Credit Card A				-			YES	NO
Referrir	ng Provider:							
Primary Care Physician: Date of Last General Health Check-Up:								
Have you had surgery for the ailment you are seeking				physical therapy for? 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):								
Cons	tant Intermittent	Sharp	Dull	Aching	Stabbing	g N	umbness	Pins/Needles
What m	nakes your pain better/woi			-				
Have yo	ou had any of the following		-		_			
	Chiropractor	Massage Therapy		EMG/NCV	Emerger	ncy Room C	are CT Sca	n
	General Practitioner	Neurologist	MRI		Podiatrist		Myelogram	
Occupational Therapy		Orthopedist	X-Rays Natu		Naturop	ath	Physical Therapy	
Do you	now have, or have you ev	er had, any of the f	ollowin	g? (C=current, P	=past)			
СР		C P				C P		
Speech Problems Strokes/TIA Thyroid Disease/Goiter Tuberculosis Vision problems Hernia Infectious Disease Gout Reiter's Syndrome Sleeping Difficulty Numbness or Tingling Weakness			Weight Gain/Loss Energy Loss Ehlers-Danlos Syndrome Chronic Fatigue Syndrome Head/Neck Injury Back Injury Shoulder Injury Elbow Injury Wrist/Hand Injury Hip/Leg injury Knee Injury Ankle/Foot Injury Yes			# # # #	RELEVANT: Pelvic Inflammatory Disease Irregular Menstrual Cycle Endometriosis Complicated Pregnancies Complicated Deliveries C-Section Deliveries Vaginal Deliveries	
Patient/Guardian Signature:							Date:	