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			**Do You Smoke?**			Recreational Drug Use
		Circulation Problems			Speech Problems			Mental Health Treatment
		Depression			Strokes/TIA			**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			**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: _____