GOOD HEALTH PHYSICAL THERAPY & WELLNESS

Please complete BOTH sides

Medical History Questionnaire

First Name: _____**Last Name:** _____ **M.I.:** _____ **Nickname:** _____

Sex designated on Insurance: _____ **Pronouns(he/she/they/other)** _____**Date of Birth:** _____/_____/_____

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

Do we have permission to discuss your medical condition with another person, i.e. Emergency Contact? **YES** **NO**

Mailing Address:_____

_____

Email Address: _____**Phone: (Cell?)**_____

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)

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

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

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

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

How did you hear about us? _____

Emergency Contact

First Name: _____**Last Name:** _____ **Relationship:**_____

Phone:_____**Referring Provider:** _____**Primary Care Dr.:**_____

Have you been diagnosed with any of the following? ***(please check)*****:**

☐ Hypermobility ☐ EDS: Ehler-Danlos Syndrome ☐ Dysautonomia

☐ POTS:Postural Orthostatic Tachycardia Syndrome ☐ MCAS:Mast Cell Activation Syndrome ☐ None apply

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 = no pain, 10 = maximum pain tolerable):* **At Rest ____ At Worst ____ At Best ____**

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

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

What makes your pain better/worse? _____

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

Have you had any of the following care for THIS injury/episode? *(please circle 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

Fall History

Have you had an injury due to a <u>fall</u> in the past year? Yes No **Have you had <u>2+ falls</u> in the last year?** Yes No

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

_____

_____

Existing or Relevant Previous Conditions

Allergies Yes No
Anemia Yes No
Anxiety Yes No
Arthritis/Swollen Joints Yes No
Asthma Yes No
AutoImmune Disorder Yes No
Cancer/Chemo/Radiation Yes No
Cardiac Conditions Yes No
Cardiac Pacemaker Yes No
Chemical Dependency Yes No
Circulation Problems Yes No
COVID 19 Yes No
Currently Pregnant Yes No
Depression Yes No
Diabetes Yes No
Dizzy Spells/Fainting Yes No
Emphysema/Bronchitis Yes No
Fibromyalgia Yes No
Fractures Yes No
Gallbladder Problems Yes No
Frequent Headaches Yes No
Hearing Impairment Yes No
Hepatitis Yes No
High Cholesterol Yes No
High/Low Blood Pressure Yes No
HIV/AIDS Yes No
Incontinence/Bowel Problems Yes No
Kidney Problems Yes No
Metal Implants Yes No Yes No
MRSA Yes No
Multiple Sclerosis Yes No
Muscular Disease Yes No
Osteoporosis Yes No
Parkinson's Yes No
Rheumatoid Arthritis Yes No
Seizures/Epilepsy Yes No
<u>Do You Smoke?</u> Yes No
Speech Problems Yes No
Strokes/TIA Yes No
Thyroid Disease/Goiter Yes No
Tuberculosis Yes No
Vision problems Yes No
Hernia Yes No
Infectious Disease Yes No
Gout Yes No
Reiter's Syndrome Yes No
Sleeping Difficulty Yes No
Numbness or Tingling Yes No
Weakness Yes No
Weight Gain/Loss Yes No
Energy Loss Yes No
Ehlers-Danlos Syndrome Yes No
Chronic Fatigue Syndrome Yes No
Head/Neck Injury Yes No
Back Injury Yes No
Shoulder Injury Yes No
Elbow Injury Yes No
Wrist/Hand Injury Yes No
Hip/Leg Injury Yes No
Knee Injury Yes No
Ankle/Foot Injury Yes No
Recreational Drug Use Yes No
Mental Health Treatment Yes No
Latex/Tape Sensitivity Yes No

<u>IF RELEVANT:</u>

Pelvic Inflammatory Disease Yes No
Irregular Menstrual Cycle Yes No
Endometriosis Yes No
#_____ Complicated Pregnancies
#_____ Complicated Deliveries
#_____ C-Section Deliveries
#_____ Vaginal Deliveries
Are you Pregnant? Yes No

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

Drug: _____ Dosage: _____ Frequency: _____ Reason: _____

Drug: _____ Dosage: _____ Frequency: _____ Reason: _____

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

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions:

_____

_____

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