Amity
PHYSICAL THERAPY

Health Questionnaire

Name: _____ Age: _____ Date: _____

Date of injury or onset of current problem: _____

How did this problem develop?

_____

_____

Have you ever injured this area before? Yes No Date: _____

Circle any tests you have had for this problem: X-Ray MRI CT scan EMG Blood
Bone density Other _____

Current Medications: 1._____ 4._____
2._____ 5._____
3._____ 6._____

Occupation: _____ Last Day Worked _____

Do you smoke? Yes No Packs/day____ Drink alcohol? Yes No How often?_____

Please check Yes (Y) or No (N) if you have ever had any of the following:

___ Chest Pain
___ Heart Attack
___ Heart Disease
___ Pacemaker/Defibrillator
___ High Blood Pressure
___ Anemia
___ Lung Conditions
___ Kidney Disease
___ Bladder Disease
___ Incontinence
___ Diabetes x ___ years
___ Emotional Disorders
___ Jaw Pain
___ Thyroid Disease
___ Infections (type) _____
___ Low Back or Joint Pain
___ Fainting/Dizziness
___Allergies to _____
___ Ulcers
___ Hernia
___ Hearing Loss
___ Orthopedic Surgery (explain)
___ Unexplained Weight Loss/Gain
___ Vision Problems
___ Night Sweats
___ Unusual Swelling/Edema
___ Unusual fatigue symptoms
___ Hospitalization (explain)
___ Cancer (type) _____
___ Other _____

Surgical Procedures:

Procedure: Date:

1._____
2._____
3._____
4._____

Hospitalizations:

Explain: Date:

1._____
2._____
3._____
4._____