Medical History Questionnaire

Date of Evaluation:

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and your therapist will assist you. Thank you!

Last Name | MI : | DOB: | Age: | Sex: | Merital Status:

First Name | Weight (lb): | Height (in): | BMI lb/in2:

Address

City | State | Zip Code

Ph: | Ex:

Occupation:

Please check any of the followings whose care you are under:

- ☐ Medical Doctor
- ☐ Psychologist/Psychiatrist
- ☐ Dentist
- ☐ Osteopath
- ☐ Physical Therapist
- ☐ Other
- ☐ Chiropractor

Date of last physical exam:

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.):

Please describe THE Reason which brought you here (Pain/symptoms, how and when):

Leisure Act.:

Have you or your blood relatives EVER been diagnosed as having any of the following conditions?

Self Yes	Self No	Family Yes	Family No		Self Yes	Self No	Family Yes	Family No	
☐	☐	☐	☐	Cancer If YES, what kind	☐	☐	☐	☐	Kidney Problem If YES, what kind
☐	☐	☐	☐	Heart Problems If YES, what kind	☐	☐	☐	☐	Rheumatoid Arthritis
☐	☐	☐	☐	High Blood Pressure	☐	☐	☐	☐	Other arthritic conditions
☐	☐	☐	☐	Circulation Problems	☐	☐	☐	☐	Depression
☐	☐	☐	☐	Ashthma	☐	☐	☐	☐	Hepatitis
☐	☐	☐	☐	Stomach Ulcers	☐	☐	☐	☐	Tuberculosis
☐	☐	☐	☐	Chemical Dependency (such as alcohol)	☐	☐	☐	☐	Stroke
☐	☐	☐	☐	Thyroid Problems	☐	☐	☐	☐	Blood clots
☐	☐	☐	☐	Diabetes	☐	☐	☐	☐	Osteoporosis
☐	☐	☐	☐	Multiple Sclerosis	☐	☐	☐	☐	Rheumatic Fever
☐	☐	☐	☐	Bronchitis	☐	☐	☐	☐	Other If YES, what kind

During the past month have you been feeling down, depressed or hopeless? ☐ Yes ☐ No

During the past month have you been bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ☐ Yes ☐ No

In the past three months, have you had or did you experience:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Chest Pain	☐	☐	Numbness/tingling	☐	☐	Urinary Tract Infection	☐	☐	Changes in bowel functio
☐	☐	Head Ache	☐	☐	Difficulty Swallowing	☐	☐	Nausea/vomitting	☐	☐	Changes in bladder functi
☐	☐	Seizure	☐	☐	Shortness of breath	☐	☐	Unexplained wt change	☐	☐	Upper respiratory infectio
☐	☐	Fever/chills/sweats	☐	☐	Dizziness	☐	☐	Changes in appetite			

Print Form

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