**Medical History Questionnaire**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Therapy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Injury:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently receiving any other care for the condition: **Y/N,** If yes please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever received therapy in the past for the condition above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Do you now or have ever had any of the following conditions?***

**Y/N** Arthritis **Y/N** Diabetes **Y/N** Numbness/Tingling

**Y/N** Osteoporosis **Y/N** Anemia **Y/N** Fever/Chills

**Y/N** High Blood Pressure **Y/N** Deep Vein Thrombosis **Y/N** Thyroid Problems

**Y/N** Heart Disease  **Y/N** Sensitivity to heat/cold **Y/N** Headaches

**Y/N** Heart Attack **Y/N** Seizures/Epilepsy **Y/N** Head Injury/Concussion

**Y/N** Pace Maker **Y/N** Metal in body or implants **Y/N** Hernia

**Y/N** Vascular Disease **Y/N** Cancer/Tumor **Y/N** Kidney/Bladder Problem

**Y/N** Stroke **Y/N** Recent weight loss/gain  **Y/N** Previous Fractures

**Y/N** Asthma **Y/N** Fatigue/Weakness **Y/N** Previous Surgeries

**Y/N** Shortness of Breath **Y/N** Tuberculosis **Y/N** Hearing Loss

**Y/N** Chronic Cough **Y/N** Hepatitis  **Y/N** Depression

**Y/N** Nausea/Vomiting  **Y/N** Recent Infections **Y/N** Substance Abuse

If you answered “yes” to any of the above or have other conditions not listed, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you presently taking any medications: **Y/N, if yes please provide \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

At this present time, would you say that your health is (circle one) Excellent Very Good Fair Poor

Are you receiving Home Health Care Services? **Y/N**

**THE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.**

**\_X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient/Guardian Signature