A BETTER LIFE d/b/a ABLE PHYSICAL THERAPY

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PAST MEDICAL HISTORY QUESTIONNAIRE

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

SS#: _____ **DOB: _____**

We at ABLe are concerned about your health. A thorough knowledge of your past medical history is crucial in providing the correct treatment. In order to serve you safely, please take the time to thoroughly complete the health questionnaire below. Please check yes or no to the following. If you answer yes, please list corresponding date.

No	Yes	Date (If Yes)	Symptom or Diagnosis
			MUSCULOSKELETAL
			Arthritis, Rheumatism, Gout, or Other Joint Problems
			Broken or Dislocated Joints
			Hand, Elbow, Shoulder Problems
			Hip, Knee, Foot Problems
			Neck or Back Problems
			Joint Replacements
			Connective Tissue, Tendon or Soft Tissue Problems
			Osteoporosis
			NEUROLOGICAL
			Head Trauma, Concussions, Injury
			Loss of Memory
			Epilepsy, Seizures, Fits or Convulsions
			Frequent or Severe Headaches or Migraines
			Dizziness, Fainting, Vertigo or Inner Ear Problems
			History of Stroke or TIA
			Pinched Nerves or Neuropathies
			Polio or Other Forms of Paralysis
			Tremors, Lack of Coordination, Parkinson's Disease
			Numbness or Paresthesias (Abnormal Sensations)
			Speech Problems (Temporary or Permanent)
			Any Neurological Disease
			CARDIAC
			History of Heart Disease
			High Blood Pressure, High Cholesterol
			Heart Irregularities or Murmur
			Pacemaker or other Implanted Device
			Chest Pain or Pressure
			Swelling of the Ankles
			Vascular or Circulatory Problems, Varicose Veins or Similar
			Blood Clots

			RESPIRATORY
			Shortness of Breath, Asthma, Cough or Wheezing
			Pneumonia, COPD, Tuberculosis or other Respiratory Condition
			GENERAL MEDICAL
			Diabetes, High or Low Blood Sugar
			Cancer, Tumor, Growths, Biopsies or Similar
			Recent Weight Loss/Gain
			Hernias or Ruptures
			Blood Disease or Anemia
			Reflux, Ulcers or Stomach Problems
			Organ Problems, Kidney Stones, Liver Disease, etc.
			Skin Problems, Rashes or Similar
			Chronic Pain or Fatigue
			Depression, Anxiety, or Emotional Distress
			Alcohol or Drug Addiction
			Autoimmune Disease, HIV
			PROCEDURES
			Pain Injections
			Specialist Consultations or Visits
			Surgeries or Medical Procedures
			Physical/Occupational Therapy Services

If you answered yes to any of the above, please explain below:

_____
_____
_____
_____

Are you allergic to anything? _____

Have you ever been in the hospital overnight? Please list date and reason for hospitalization. _____

_____

Have you ever had surgery or have been advised to have one? If so, please list date and reason for surgery/type of procedure. _____

_____

When was the last time you were at a doctor's office? What was the reason for your visit?

_____
_____

Do you have any significant family medical problems? _____

Have you had any diagnostic exams and blood work done recently? For what reason? Please list date performed and the relevant results.

_____

_____

For Women: Are you pregnant? _____ How many months? _____

Please list any medication (prescription AND over the counter), herbs, supplements, and home remedies you are currently taking. _____

_____

_____

Do you have any condition which may limit your daily living and work activities? _____

_____

Have you ever had any serious effects from physical activities you have done? _____

_____

Do you smoke? If so, how much? _____

Do you drink alcohol? If so, how much? _____

Do you exercise? What type and how often? _____

Are you Left handed or Right handed? _____

Is there anything else you would like to inform us about? _____

_____

Who should we contact in case of emergency?

Name _____ Relationship _____ Tel _____

Who is authorized to receive your Protected Health Information (PHI)?

Name _____ Relationship _____ Tel _____

I attest that I have answered the above questions to the best of my ability.

Name: _____ Signature: _____ Date: _____