ONSITE PHYSIO

4215 Southpoint Blvd
Suite 101
Phone 866-907-4797
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Medical History Questionnaire

Name		Today's Date	
D.O.B.		Height/Weight:	
Referring Physician:		Date of next physician's visit:	

What problems are you having, what brings you to therapy?

Date of injury/When did your pain start? ___ ___ Date of surgery: _____
How did you hurt yourself? _____
Do you smoke? Y N Do you exercise regularly? Y N
Do you have any drug allergies: Y N Please specify: _____
Please list your current medications: _____

Have you ever had the following (circle yes or no, leave blank if uncertain)

Anemia	Y / N	Kidney Disease	Y / N	Fainting	Y / N	Pacemaker	Y / N
Arteriosclerosis	Y / N	Thyroid Disease	Y / N	Dizziness	Y / N	Metal Implants	Y / N
High/Low Blood Pressure	Y / N	Emphysema	Y / N	Asthma	Y / N	Migraines	Y / N
Phlebitis	Y / N	Respiratory Issues	Y / N	Epilepsy	Y / N	Diabetes	Y / N
Arthritis	Y / N	Heart Disease	Y / N	Stroke	Y / N	Neck	Y / N
Gastraintestinal Issues	Y / N	Back Issues	Y / N	Cancer	Y / N	Pregnant (Now)	Y / N

My goal(s) for therapy: _____

My signature below confirms that this medical history is accurate to the best of my knowledge:

_____ _____
Patient Signature Date

_____ _____
Therapist Signature Date