THERA-DYNAMICS PHYSICAL THERAPY

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Medical History Questionnaire

The purpose of this questionnaire is to determine if you might have a medical condition that could affect your treatment here.

Name: _____

Have you had surgery due to this injury?: Yes / No Number of Surgeries: _____

Type of Surgery: _____ Date(s) of Surgery: _____

Have you had any surgeries in the past year?: _____

What prescription or non-prescription medications are you currently taking?

_____

_____

Have you had any of the following medical or rehabilitative services for this injury?
(Please circle those that apply)

Physical Therapy	General Practitioner	Orthopedist	X-rays
Chiropractor	Neurologist	Podiatrist	MRI / MRA
Occupational Therapy	Cardiologist	Physiatrist	CT Scan
Massage Therapy	Emergency Room Care		EMG / NCV

Do you have or have you had **ANY** of the following?
(Please circle those that apply)

Anemia	Arm / Elbow / Hand Injury or Surgery	Angina
Artificial Joint(s)	Leg / Ankle / Foot Injury or Surgery	Arthritis
Asthma	Neck injury / Surgery	Cancer
Back Injury or Surgery	Numbness Or Tingling	Coronary Heart Disease
Blood Clot / Emboli	Osteoporosis	Diabetes
Bronchitis	Severe Or Frequent Headaches	Gout
Chest Pain / Shortness of Breath	Swelling Of Limbs / Joints	Heart Attack
Dizziness Or Fainting Spells	Thyroid Trouble / Goiter	High Blood Pressure
Emphysema	Vision Or Hearing Difficulties	Low Blood Pressure
Epilepsy / Seizures	Weakness	Pacemaker
Hernia		Stroke / TIA

Do you have any known allergies?: _____

Do you smoke?: Yes / No Do you have sleeping problems or difficulties?: Yes / No

Do you have emotional or psychological problems?: Yes / No

Women: Are you pregnant?: Yes / No If yes, what is your due date?: _____

Please list any other information that you feel would assist us in your care: _____

_____

Patient Signature: _____ Date: _____

Please be sure to let us know if this information changes.