



# Past Medical History Questionnaire

Please fill out the following questionnaire as completely as possible.

This enables your Therapist to establish a clinical profile that is safe and appropriate for your individual needs.

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

Date: \_\_\_\_\_

## MEDICAL HISTORY:

I have a history of: (check any that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Kidney Problems     | <input type="checkbox"/> Bronchitis                    |
| <input type="checkbox"/> Cardiac Conditions   | <input type="checkbox"/> Liver Problems      | <input type="checkbox"/> Tuberculosis                  |
| <input type="checkbox"/> Heart Attack         | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Hepatitis A B C               |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Claustrophobia      | <input type="checkbox"/> Ulcers                        |
| <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Nervous Disorders   | <input type="checkbox"/> Osteoporosis                  |
| <input type="checkbox"/> Seizures             | <input type="checkbox"/> Vision Problems     | <input type="checkbox"/> Bladder/Incontinence Problems |
| <input type="checkbox"/> Dizzy Spells         | <input type="checkbox"/> Sensitivity to Heat | <input type="checkbox"/> Surgery: _____                |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Sensitivity to Cold | <input type="checkbox"/> Frequent Falls                |
| <input type="checkbox"/> Allergies            | <input type="checkbox"/> Speech Problems     | <input type="checkbox"/> Headaches                     |
| <input type="checkbox"/> Fractures            | <input type="checkbox"/> Metal Implants      | <input type="checkbox"/> Hearing Problems              |
| <input type="checkbox"/> Stroke               | <input type="checkbox"/> AIDS                | <input type="checkbox"/> I am or may be Pregnant       |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> HIV                 | <input type="checkbox"/> Other _____                   |

I currently have difficulty with :

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Driving              | <input type="checkbox"/> Walking                 | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bending at the waist | <input type="checkbox"/> Getting up from a chair | <input type="checkbox"/> Reaching    |

Please list activities you have difficulty performing due to pain/symptoms and indicate degree of difficulty:

- |         |         |          |        |                   |
|---------|---------|----------|--------|-------------------|
| 1 _____ | minimal | moderate | severe | unable to perform |
| 2 _____ | minimal | moderate | severe | unable to perform |
| 3 _____ | minimal | moderate | severe | unable to perform |
| 4 _____ | minimal | moderate | severe | unable to perform |
| 5 _____ | minimal | moderate | severe | unable to perform |

Are your symptoms: (check one)

- |  |   |                                   |
|--|---|-----------------------------------|
| <input type="checkbox"/> Getting Worse | <input type="checkbox"/> Getting Better | <input type="checkbox"/> The Same |
|--|---|-----------------------------------|

I certify this information is true and correct to the best of my knowledge.

\_\_\_\_\_  
Signature of Patient or Guarantor if Patient is a Minor

\_\_\_\_\_  
Date