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)

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

I currently have difficulty with :

- ☐ Driving
- ☐ Bending at the waist
- ☐ Walking
- ☐ Getting up from a chair
- ☐ Other ________________
- ☐ 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)

- ☐ Getting Worse
- ☐ Getting Better
- ☐ 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

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