EXCELLENCE IN PHYSICAL THERAPY

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HEALTH QUESTIONNAIRE

FIRST: _____ MI: _____ LAST: _____

*Please check **ALL** that apply to your medical history:*

__ Cancer: (type)_____
__ High Blood Pressure
__ Cardiac Condition
__ Pacemaker
__ Diabetes: (type)_____
__ Neurologic: (type)_____
__ Allergies: (type)_____
__ Vascular Problem: (type)_____
__ Accident/Trauma: (date)_____
__ Intestinal Problem: (type)_____

__ Arthritis: (type)_____
__Osteoporosis
__Headaches: (type)_____
__Dizziness: (type)_____
__ Joint Replacement: (location)_____
__Metal Implants: (location)_____
__ Respiratory Condition: (type)_____

Pregnant? Yes No
__ Incontinence
__ Vision Impaired
__ Hearing Impaired
__ Smoker
__ Stroke
__ Recurrent Fever/Chills

If further explanation required on any of the above, please use this space:

_____
_____

Recent/Relevant Surgeries: _____
_____

Do you presently take medication? _____ Yes _____ No If yes, please fill out list or attach your own:

Medication/Supplement/Vitamin Name:	**Dose:**	**Frequency:**	**Diagnosis Taken For:**
1 _____	_____	_____	_____
2 _____	_____	_____	_____
3 _____	_____	_____	_____
4 _____	_____	_____	_____
5 _____	_____	_____	_____
6 _____	_____	_____	_____
7 _____	_____	_____	_____
8 _____	_____	_____	_____
9 _____	_____	_____	_____
10 _____	_____	_____	_____

I certify that the above information is correct to the best of my knowledge. I understand and agree that I am personally responsible for full payment of all physical therapy services rendered to me. I hereby transfer/assign payment of any physical therapy insurance benefits direct to Excellence In Physical Therapy and authorize release of any information regarding my treatment that is required by my insurance carrier to obtain such a payment.

SIGNATURE:_____DATE:_____