Past Medical History Questionnaire

Patient Name_____Date of birth_____

Reason for Therapy_____Date of Injury/Onset_____

Have you ever received therapy for the condition named above?_____If so, when?_____

Treatment received:_____Was your treatment successful?_____

Could you be or are you pregnant?_____

Do you now or have you ever had any of the following?

condition	*Yes*	*No*	*Condition*	*Yes*	*No*	*Condition*	*Yes*	*No*
Arthritis			**Diabetes**			**Thyoid Problems**		
Osteoporosis			**Anemia**			**Headaches**		
High Blood Pressure			**Hypersensitivity to heat/cold**			**Head Injury/ concussion**		
Heart Disease			**Swelling in Ankles**			**Hernia**		
Hear Attack			**Deep Vein Thrombosis (DVT)**			**Kidney/Bladder Problems**		
Pacemaker			**Seizures/Epilepsy**			**Previous Fracture**		
Vascular Disease			**Metal in Body or surgical implants**			**Previous Surgeries**		
Stroke			**Cancer/Tumor**			**Hearing Loss**		
Shortness of Breath			**Recent weight gain or loss**			**Depression**		
Chronic Cough			**Current Infection(s)**			**Anxiety**		
Asthma			**Tuberculosis**			**Substance Abuse**		
Fainting Spells			**Hepatitis**			**Other**		

If you answered "yes to any of the above, please explain and give approximate date(s):
Do you have any allergies? YES NO list allergies:
Are you presently taking any medications? YES NO list medications and specify condition:
The information is correct to the best of my knowledge.
X
Patient/Parent/Guardian Signature Date: