Past Medical History Questionnaire

Name: ____

DOB: ___________________________ Date of injury/onset: ___________________________

Have you ever received therapy before? YES NO

If so, when? ____

Could you be, or are you pregnant? YES NO

Please Check If You Have The Following Medical History

	YES		YES
Arthritis	______	Metal Implants	______
Osteoporosis	______	Cancer/Tumor	______
High Blood Pressure	______	Recent Weight Loss/Gain	______
Heart Disease	______	Current Infection(s)	______
Heart Attack	______	Tuberculosis	______
Pacemaker	______	Hepatitis	______
Vascular Disease	______	Thyroid Problems	______
Stroke	______	Headaches	______
Asthma	______	Head Injury/Concussion	______
Shortness of Breath	______	Hernia	______
Chronic Cough	______	Kidney/Bladder Problems	______
Fainting Spells	______	Previous Fractures	______
Diabetes	______	Previous Surgeries	______
Anemia	______	Hearing Loss	______
Hypersensitivity to Heat/Cold	______	Depression	______
Swelling in Ankles	______	Anxiety	______
Seizures/Epilepsy	______	Substance Abuse	______
Deep Vein Thrombosis	______	Allergies	______
		Other	______

If you answered “yes” to any of the above, please explain and give approximate date(s):

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Are you presently taking any medications? If “yes”, list all medications.

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The information above is correct to the best of my knowledge.

____ ________________________

Patient/Parent/Legal Guardian Signature Date