GENERAL HEALTH QUESTIONS

Have you had a similar problem before? ☐ Yes ☐ No If yes, when? ____________________

Have you had treatment for this problem before? ☐ Yes ☐ No If yes, what kind?

☐ PT ☐ OT ☐ Chiropractic ☐ Massage ☐ Splint/Brace ☐ Injections ☐ Other: ____________

☐ Cast (duration:________weeks)

Have you had any testing for your current problem? ☐ Yes ☐ No

☐ X-rays ☐ Bone scan ☐ CT scan ☐ MRI ☐ Nerve tests ☐ Blood tests ☐ Other: ____________

Results of testing (if known): ____________________

How would you rate your overall health? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Are you currently taking any medications? ☐ Yes ☐ No If yes, please list medications below.

____

____

If you have any **medication allergies**, please list them here: ____________________

Age: ______ Height: ______ Weight: ______ Do you exercise regularly? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes, how much? ___________ For how long? ___________

If female, are you pregnant at this time? ☐ Yes ☐ No ☐ Not applicable

Have you had any long-term use of prednisone, cortisone, steroids or inhalants? ☐ Yes ☐ No If yes, please specify: __________

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Have you had any of the following at any time in your life? Please circle

Polio	Asthma	Allergies	Fibromyalgia	Tuberculosis	Lung problem	Allergy to latex
Lupus	Hepatitis	Phlebitis	Blood clots	Osteoporosis	Heart disorder	Allergy to adhesives
Stroke	Seizures	Diabetes	Concussion	Sprain/Strain	Hypoglycemia	Bleeding disorder
Cancer	Arthritis	Whiplash	Broken bone	Metal implant	Nerve disorder	High blood pressure

Connective tissue disorder   Unusual/frequent headaches   Major accident with injuries/fractures   Kidney disease

Orthopedic Surgery (bones or joints): ____________________   Other surgery: ____________________

Please explain any circled items: ____________________

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What are your goals and expectations for Physical/Occupational Therapy? ____________________

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How did you hear about us? Please circle all that apply

Aquasox   Attorney   Drive by   Friend/Family   Insurance Company   Doctor   School   Website   Yellow Pages   Other

Patient Signature: ____________________   Date: ____________