MR# _____

HEALTH QUESTIONNAIRE

Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Home Phone Number: _____ Cell Number: _____

SS#: _____ Marital Status: _____

Email Address: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Number: _____

Employer: _____ Employer Phone: _____

How did you hear about us? ____ Doctor ____ Friend ____ Yellow Pages ____ News Ad _____ Fitness Center ____ Former Patient
Name of Referring Person: _____

Referring Doctor: _____ Date of Injury: _____

Do you have, or previously had, any of the following conditions?

	Yes	No		Yes	No
Allergies			Hepatitis		
Aneurysm			High Blood Pressure		
Asthma			Implanted Stimulator		
Blood Clot			Low Blood Pressure		
Cancer			Osteoporosis		
Chest Pain			Pacemaker		
Congestive Heart Failure			Respiratory Infection		
Diabetes			Shortness of Breath		
Epilepsy			Stroke		
Fainting Spells			Are you currently pregnant?		
Heart Attack			Do you smoke?		
Heart Problems			Other		

List any medications your are currently taking: _____

Past surgeries: _____

_____

Are you currently receiving any type of Home Health assistance? Yes _____ No _____

I have answered these questions to the best of my ability. If there is any change in my contact information or my physical condition, I will inform my physical therapist.

_____ _____
PATIENT OR PATIENT'S AGENT DATE