HEALTH QUESTIONNAIRE

TPTC
1230 NORTH CONVENT, SUITE A
BOURBONNAIS, IL 60914
THE PHYSICAL THERAPY CENTER LTD.
(815) 935-8782

Name: _____ Date: _____

Date of Birth: _____ M.D. _____

Medical History: Please indicate if you currently have or have had a history of the following (check all that apply):

☐ High blood pressure	☐ Injury to neck/back/spine	☐ Cancer
☐ Heart problems	☐ Orthopedic injuries/fractures	☐ Diabetes
☐ Pacemaker	☐ Osteoporosis	☐ Depression/anxiety
☐ Circulation problems	☐ Arthritis	☐ Panic attacks
☐ Leg/Ankle swelling	☐ Metal Implants	☐ Bowel/Bladder problems
☐ Asthma	☐ Headaches	☐ Kidney problems
☐ Breathing problems	☐ Fainting spells	☐ Hearing problems
☐ Emphysema	☐ Stroke/paralysis	☐ Vision problems
☐ Smoker	☐ Epilepsy/seizures	☐ Currently pregnant
☐ Allergies	☐ Dizziness/lightheadedness/falling	☐ Other: _____

For any condition checked above, please explain and give approximate dates:

_____

Surgeries: List any surgeries/hospitalizations you have had and the date:

_____

_____

Medications: List any medications you are taking:

_____

_____

Previous PT/OT/Chiropractic care this year? ☐ Yes ☐ No

If Yes, explain: _____

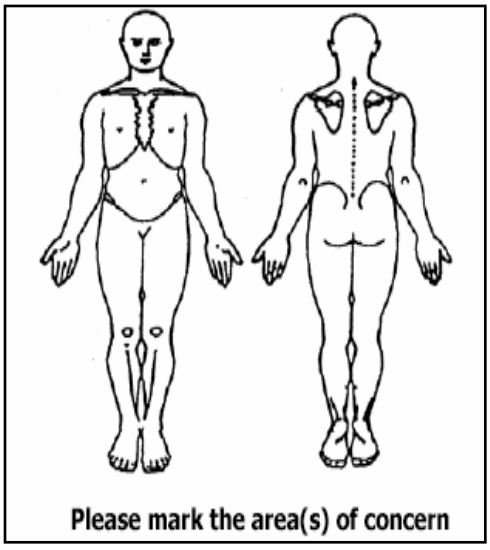
Type of Pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Stabbing ☐ Shooting ☐ Tingling ☐ Numbness

Please rate your pain: **No pain** **Worst pain**

Now	1	2	3	4	5	6	7	8	9	10
At its best	1	2	3	4	5	6	7	8	9	10
At its worst	1	2	3	4	5	6	7	8	9	10

Rate your overall Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Lifestyle/Exercise Routine: ☐ Very Active/Athletic (5x/wk) ☐ Regular Exercise (1-3x/wk) ☐ Infrequent Exercise ☐ Sedentary



Patient signature: _____ Date: _____