Body in Balance Physical Therapy Medical History Questionnaire

Name:_____ **DOB**:_____

What brings you to the clinic today? How long has this been bothering you?

_____

_____

What makes it feel better? Worse?

_____

_____

Have you ever been treated for this problem before?

_____

_____

Have you ever been diagnosed as having any of the following conditions?

	YES	NO
Heart Problems	_____	_____
Diabetes	_____	_____
Thyroid Problems	_____	_____
Epilepsy/Seizures	_____	_____
Cancer	_____	_____
Hypertension (high blood pressure)	_____	_____
Blood disorders (e.g. anemia, hemophilia)	_____	_____
Asthma/breathing problems	_____	_____
Gastrointestinal disorders	_____	_____
Neurological disorders(including stroke)	_____	_____
Arthritis	_____	_____
Attention deficit hyperactive disorder	_____	_____
Depression/Anxiety	_____	_____
Panic attacks	_____	_____

Have you recently experienced any of the following?

Change in bowel/bladder habits	_____	_____
Unexplained weight loss or gain	_____	_____

Have you been exposed to any communicable/infectious diseases? (e.g. Tuberculosis, Hepatitis, HIV)
YES NO

Is there any possibility that you are currently pregnant? YES NO N/A

Please list any past injuries for which you have been treated and any previous surgeries (include approximate date):_____

_____

_____

_____

Please list any medications you are currently taking(including non-prescription):_____

_____

_____

_____