



# Temple Physical Therapy

230 George Street, 5th Floor  
 New Haven, Connecticut 06510  
 203.498.5980 Phone  
 203.498.5999 Fax

## Health Questionnaire

Thank you for completing this form. It will help us to develop a safe treatment program.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Please list all current medications (may use back of form if needed):

Medication Name (Dose if known):	Prescribed for:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Do you smoke? Yes No Packs per day: \_\_\_\_\_ Drink Alcohol? Yes No How often? \_\_\_\_\_

Awareness of Diagnosis: \_\_\_\_\_ unaware \_\_\_\_\_ somewhat aware \_\_\_\_\_ fully aware

Awareness of Prognosis: \_\_\_\_\_ unaware \_\_\_\_\_ somewhat aware \_\_\_\_\_ fully aware

So you know the expected frequency and duration of treatment? Yes No \_\_\_\_\_ x/wk x \_\_\_\_\_ wks

### PAST HISTORY: Please check if you ever had any of the following:

	YES	NO		YES	NO
Rheumatic Fever	_____	_____	Cancer (Type) _____	_____	_____
Chest Pain	_____	_____	Emotional Disorders	_____	_____
Heart Attack	_____	_____	Jaw Pain	_____	_____
Heart Disease	_____	_____	Thyroid Disease	_____	_____
High Blood Pressure	_____	_____	Colitis	_____	_____
Controlled with: Meds: _____ Diet: _____			Ulcers	_____	_____
Anemia/Blood Disorder	_____	_____	Gallbladder Disease	_____	_____
Kidney/Bladder Disease	_____	_____	Frequent Fainting/Dizziness	_____	_____
Gout	_____	_____	Infectious Diseases:		
Hernia	_____	_____	Chicken Pox	_____	_____
Lung Conditions	_____	_____	Measles	_____	_____
Inhaler required	_____	_____	Hepatitis	_____	_____
Inhaler carried	_____	_____	Herpes	_____	_____
Diabetes x _____ yrs	_____	_____	Allergies (Please list on back)		
Controlled with: Meds: _____ Diet: _____			Latex	_____	_____
			Seasonal	_____	_____
			Food	_____	_____

Please list any other medical conditions: \_\_\_\_\_

### Hospitalizations and/or and Serious Injuries

### Surgical Procedures

Explain	Date	Procedure	Date
1. _____	_____	1. _____	_____
2. _____	_____	2. _____	_____
3. _____	_____	3. _____	_____
4. _____	_____	4. _____	_____

Signature: \_\_\_\_\_ Date: \_\_\_\_\_