



HEALTH QUESTIONNAIRE

NAME: _____

D.O.B: __/__/__

Thank you for choosing Elevation Physical Therapy for your rehabilitation. Please take a few moments to answer the following questions in regard to your health, which will better assist the physical therapist / athletic trainer in meeting your specific needs or concerns.

How did you hear about us? _____

Is there anyone involved in your care or payment of your care with whom we may share medical information?

YES NO If YES please list names and contact number:

1.Name: _____ 2.Name: _____ 3.Name: _____

1.Number: _____ 2.Number: _____ 3.Number: _____

Tell us a little bit about what your pain, limitations and problems are: _____

What are your specific goals? _____

MEDICAL HISTORY

Diabetes: Y N When were you diagnosed? _____

Do you have concerns about diabetes? Y N

Heart Condition? Y N Cardiac Surgeries? Y N

High Blood Pressure? Y N High Cholesterol? Y N

Respiratory Problems? Y N

If so, how do you control these conditions? _____



Previous surgeries (List procedure, side and date): _____

Prior orthopedic (bones, joints, muscles) injuries or pain: _____

Bone density concerns: Y N Cracking joints: Y N

CIRCLE THOSE WHICH APPLY: Headaches, tinnitus (ringing in ears), TMJ (jaw pain), skin problems, low energy, anxiety, depression, poor balance, osteoporosis, kidney disease, fibromyalgia, ulcers, liver disease, lung disease, Rheumatoid Arthritis, Cancer (if so please explain): _____

Pregnancies: _____

Do you feel rested in the morning? Y N Do you have challenges with sleep? Y N

Do you have digestive issues? Y N

Heart Burn _____ Constipation _____ Nausea _____ Loose Bowels _____

Please list any other medical conditions not previously mentioned: _____

Please list all medication you are currently taking: _____

What are you currently taking for nutrition supplements? _____
