Confidential General Health Screening Questionnaire

The information requested in below form will ensure optimum care in your treatment. This form is to be completed by each patient.

Name:………………………………………………………….. Occupation:……………………………………
Have you received therapy before? …………….If Yes? For What?...
Please briefly write your primary reason for Physiotherapy consult:……………………………………………...
……...
Are you currently taking any medications? (Yes) (No) If Yes Please list:………………………………………...
……...
FOR WOMEN: Are you currently Pregnant or think you might be Pregnant? (Yes) (No)………………………..

Do you CURRENTLY have or have a HISTORY of any medical condition(s)? (Please check all that apply)

	Broken bones/ Fractures		Heart Problems
	Joint Problems		Infection (Urinary tract, chest, etc)
	Diabetes		Osteoporosis
	Allergies		Lung Problem/ Asthma
	Varicose Veins/ Arterial problems		Cancer
	Sleep Problems		Depression
	Skin Disease		Other

Any Surgeries/ Metal Implants……………………………………………………………………………….......

Within the past year have you had any of the following symptoms? (Please check all that apply)

	Chest Pain/ Heart Palpitations		Vomiting/ Nausea
	Shortness of Breath		Difficulty Swallowing
	Dizziness/ Blackouts		Urinary Problems/ Bowel Problems
	Loss of Balance/ Coordination		Fever/ Chills/ Sweats(Night Sweats)
	Weakness in arms and legs		Weight Gain
	Unexplained Weight Loss		Loss of Appetite
	Unrelenting/ Constant night pain		

General Health

Do you have History of Oral Steroid Use?..
Is there anything else about your HEALTH we should be aware of?...
Give Details…………………………………………………………………………………………………...
Have you had recent XRAYS?..

In the event of an EMERGENCY, please contact:
Name:…………………………………………………….. Relation:……………………………………....................
Phone Number:……………………………………

Signature Of Patient:……………………………………………Date:……………………………………………