PHYSICAL THERAPY - GENERAL HEALTH QUESTIONNAIRE

Name: _____ Primary Care Physician: _____

What problem has brought you to physical therapy? _____
Onset Date: _____

MEDICAL HISTORY: (Check all conditions that apply to you)

MEDICAL CONDITIONS	Check	MEDICAL CONDITIONS (CONT)	Check	PAIN (other than today's diagnosis)	Check	OB/GYN HISTORY	Check
Diabetes		Constipation		No Pain Elsewhere		Pelvic Pain	
Fainting Spells		Diarrhea		Feet		Menstrual Pain	
Shortness of Breath		Hemorrhoids		Knees		PMS	
Dizziness		Urinary Leakage		Hips		Hysterectomy Vaginal	
Kidney Disease		Irritable Bowel Syndrome		Shoulders		Hysterectomy Abdominal	
Thyroid Problems				Abdomen		Ovaries Removed	
Difficulty Breathing				Back/Neck Pain		C-Section	
Labored Breathing		**FAMILY HISTORY**		Other		Laproscopic Surgery	
Lung Problems		Heart Attack				Scar Pain/Stuck Scar	
Cancer		Heart Disease		**HEART/ CIRCULATION**		"Falling Out" Feeling	
Depression/Anxiety		High Blood Pressure		Heart Disease/ Heart Attack		Hormone Replacement	
Visual Impairment		Diabetes		High Blood Pressure		Using Vaginal Cream	
Hearing Impairment		Other		Stroke		Pregnant	
Cigarette smoker				Pacemaker		How far along?	
History of smoking Not smoking now		**SURGICAL HISTORY**		Heart Surgery		Number of Pregnancies _____	
Osteoporosis		Joint Replacements		Discomfort in Chest		Number of Children _____	
Scoliosis		Back or Neck		Angina			
Fibromyalgia		Abdominal		High cholesterol			
Arthritis		Knee		High Triglycerides			
Dropped Arches/Feet		Other Joints		Ankle Swelling			
Constipation		Surgery Bladder		Clotting Disorder			
Diarrhea		Other					

Is there anything else you would like to share about yourself?

_____

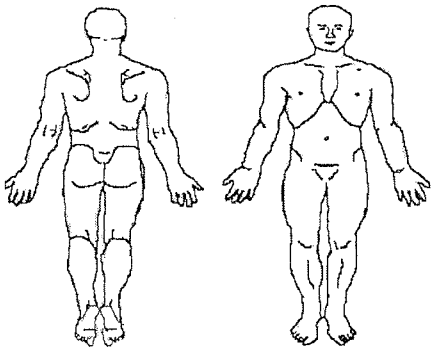
_____

_____

_____

_____

Indicate where you have pain or other symptoms:



_____ _____

Your Signature **Date**