Physical Therapy Health Questionnaire

Personal Information

Name_____Date_____

Address_____

DOB_____ Gender: M/F

Telephone number (preferred for contact)_____

Alternate number_____Email address_____

Referring physician (if applicable)_____

Emergency contact name and telephone number_____

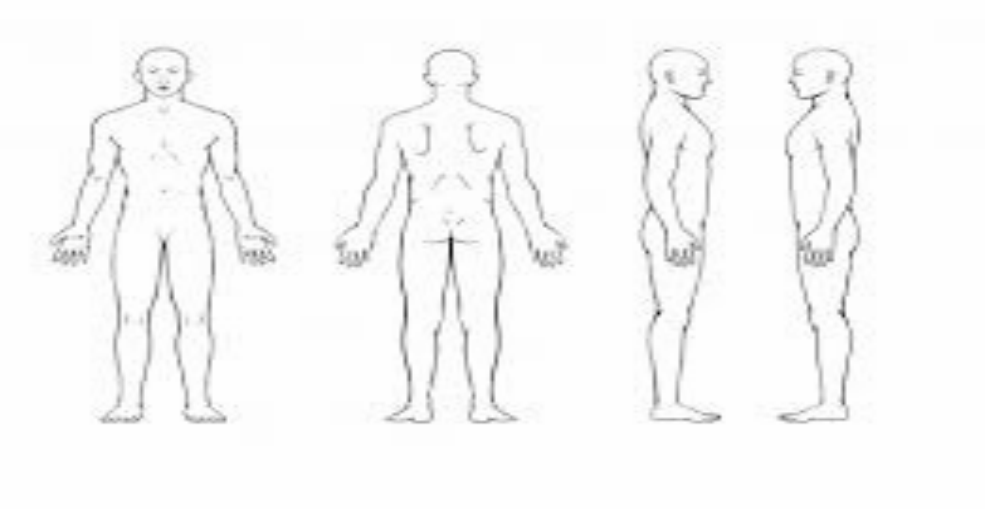
How did you hear about our services?_____

Health Information

Are you currently experiencing physical pain? Yes No
If yes, please
explain_____
_____
_____

Please rate your current pain level on a pain scale of 0 (no pain at all) to 10 (worst pain imaginable) and shade or circle area(s) on the body diagram that show your pain areas:

0 1 2 3 4 5 6 7 8 9 10



Past Medical History

Have you ever had or been diagnosed with any of the following conditions? Circle all that apply.

Cancer (type; date)_____	Heart problems
Stroke	Lung problems
Multiple sclerosis	Epilepsy/Seizures
Difficulty breathing	Arthritis
Head injury	Osteoporosis/osteopenia
Pain at night	Unexplained weight loss
Depression	Anxiety

Are you currently pregnant? Yes/No
If yes, how many weeks gestation?

Please list any surgeries, traumas, or accidents:

_____
_____
_____
_____

Please list any current medications (over-the-counter and prescription) vitamins and supplements you are currently taking:

_____
_____

I hereby consent to participation in physical therapy treatment at On Point Acupuncture and Wellness. I verify that I have answered my health information as accurately as I am aware, and that if the physical therapist finds a contraindication to care at this time, I will be referred to the appropriate medical professional. I understand

that I have the right to refusal of any treatment. I understand that if I experience health changes during my course of physical therapy treatment it is my obligation to share that with my physical therapist, as it may alter the course of appropriate care. I understand it may be necessary for the physical therapist to contact another health care professional to coordinate medical treatment. My signature gives permission to the physical therapist to release medical records as needed for the reasons listed above, within HIPAA accordance.

Client's name and date_____Signature_____