Health Questionnaire

In order to ensure optimum care in therapy, this form is to be completed by each patient. All information will remain confidential and will be part of your therapy program.

PATIENT'S NAME: ____________________________ DATE: _______________

	Question	YES	NO
1.	Do you have DIABETES? ………………………………………..		
2.	Do you have HYPERTENSTION (high blood pressure)? …………..		
3.	Do you have a history of HEART DISEASE (chest pain)? ………..		
4.	Do you have a PACEMAKER? ………………………… …………..		
5.	Do you have EPILEPSY? ………………………………………....		
6.	Have you had any major SURGERY, TUMORS, or SERIOUS ILLNESS? ……………………………………………………...		
7.	Do you have any major ALLERGIES or SENSITIVITIES to drugs, tape, creams, heat or cold? ……………………………………….. Please list: _______________________________________		
8.	Do you have ASTHMA or other RESPIRATORY CONDITIONS?..		
9.	Are you PREGNANT? ……………………………………………		
10.	Do you have any METAL (implants) in your body? ………………..		
11.	Are you taking any MEDICATION at present? …………………….. Please list: _______________________________________		
12.	Have you had recent XRAYS? …………………………………….		
13.	Are you receiving any other TREATMENT at present? ……………. i.e. chiropractor, chemotherapy, radiation therapy, massage therapy..		
14.	Have you had PHYSIOTHERAPY previously? ……………………. If so, when? __________ For what reason? ________________		
15.	Is there anything else about your HEALTH we should be aware of?.. Give details: ______________________________________		

In the event of an EMERGENCY, please contact:
Name: ________________________________
Phone Number: __________________________
Relation: ______________________________

SIGNATURE OF PATIENT: ____

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