

/// PEAK PERFORMANCE

PHYSICAL THERAPY & SPORTS TRAINING

Medical History Questionnaire

Patient Name		Date of Birth		Age	
Reason for Therapy		Date of Injury or Onset			
Are you currently receiving any other care for the condition mentioned above? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please list:					
Have you ever received therapy in the past for the condition mentioned above? <input type="checkbox"/> No <input type="checkbox"/> Yes If so, when?					
Previous Treatment Received:		Previous Treatment: <input type="checkbox"/> Successful <input type="checkbox"/> Unsuccessful			
Have you received therapy services for other problems/conditions this calendar year? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please list:					
Can you be or are you pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes					
Do you now or have you ever had any of the following conditions?					

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Fever/Chills	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hypersensitivity to Heat/Cold	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Swelling In Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Deep Vein Thrombosis (DVT)	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury/Concussion	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Metal in Body or Surgical Implants	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Previous Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss or Gain	<input type="checkbox"/>	<input type="checkbox"/>	Previous Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue/Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/Light Headedness /Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infection(s) or Infection in the past 3 months	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "yes" on any of the above or have other conditions not listed, please explain and give approximate date(s):

Do you have any allergies? No Yes, list allergies:

Are you presently taking any medications? No Yes, list medications and specify condition:

At the present time, would you say that your health is (circle one): Excellent Very Good Fair Poor

The information is correct to the best of my knowledge.

X	
Patient/Parent/Guardian Signature	Date