



PROACTION
PHYSICAL THERAPY
HEALTH QUESTIONNAIRE

Patient Name: _____

Date: _____

Check conditions (✓) you have or have had in the past:

- | | | |
|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Irregular/Rapid Heart Rate |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Ulcers |

Other: _____

Please explain any above checked item: _____

Past surgeries:

Allergies:

Medications:

| Medication Name | Reason |
|-----------------|--------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

If this form is **NOT** completed by patient, please fill in below:

Completed by: _____ Relation to Patient: _____