

Patient Name: \_\_\_\_\_  
Date: \_\_\_\_\_

ProAction Physical Therapy

**HEALTH QUESTIONNAIRE**

**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: \_\_\_\_\_  
\_\_\_\_\_

**Prior injuries:**

\_\_\_\_\_  
\_\_\_\_\_

**Past surgeries:**

\_\_\_\_\_  
\_\_\_\_\_

**Allergies:**

\_\_\_\_\_

<b>Medication Name</b>	<b>Medications: Frequency</b>	<b>Reason</b>
_____		
_____		
_____		
_____		
_____		
_____		
_____		

Completed by: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

**Onset Date of Current Issue:** \_\_\_\_\_

**Circle Current Level of Pain:** 0 1 2 3 4 5 6 7 8 9 10  
(no pain) (max. pain)