PROACTION
PHYSICAL THERAPY

HEALTH QUESTIONNAIRE - NON MEDICARE PATIENTS

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Date of Injury: _____ **Rate Your General Health:** ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

☐ **Male** ☐ **Female** **HEIGHT:** _____ **WEIGHT:** _____

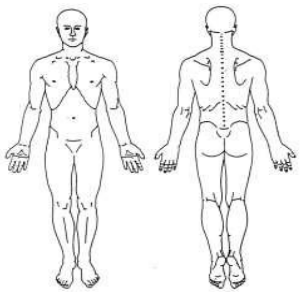
Circle Current Level of Pain: **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**_____
(no pain) **(max pain)**

How many times have you FALLEN in the past year? _____ **Were you injured?** ○ **Yes** ○ **No**

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

☐ Diabetes	☐ Chest Pain	☐ High Blood Pressure	☐ Asthma
☐ Cancer	☐ Heart Disease	☐ Arthritis	☐ Depression
☐ Blood Clots	☐ Epilepsy/Seizures	☐ Osteoporosis	☐ HIV Positive
☐ Stroke	☐ Headaches/Migraines	☐ Circulatory Problems	☐ Hepatitis B or C
☐ Pacemaker or Metal Implants		**Allergic to Latex? Yes No**	

Please explain any condition checked above: _____



Please mark on the body diagrams the areas where you feel pain:

Would you describe your pain as:

☐ **Dull** ☐ **Aching** ☐ **Sharp** ☐ **Burning**

Do you have any numbness or tingling? ☐ **Yes** ☐ **No**

Does your pain awaken you at night? ☐ **Yes** ☐ **No**

Activity Limitation:

Please list 3 important activities that you are unable to do or having difficulty with as a result of your problem:

1._____ **2.** _____ **3.** _____

Previous Injuries: **To the same area:** ☐ **Yes** ☐ **No**

_____

_____

Current or Past Surgeries: **To the same area:** ☐ **Yes** ☐ **No**

_____

_____

List Any None or Prescription Drugs/Supplements:

Medication Name	**Dosage**	**Reason for taking**
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____

Signature: _____ **Date** _____

Your Medical History is very important. By signing, you acknowledge that the above information is accurate and true.