Medical History Questionnaire

Name: ____

Are you currently receiving home health or chiropractic services? No Yes _______________________________________
(Home Health Agency)

Have you had any imaging performed? No Yes If yes, what type? X-Ray MRI CT Scan Doppler Ultrasound

Do you have any allergies? Yes No If yes, please list ____

PLEASE CIRCLE HEALTH PROBLEMS PAST OR PRESENT

COVID-19	Coughing	Fever	
Cardiac	Muscular	OB/GYN	Weight ________________
Circulatory	Endocrine	Psychological	
High Blood Pressure	Digestive	Drug Dependency	Height _________________
Diabetes	Bladder	Alcohol	
Respiratory	Bowel	Smoking	
Cancer	Headaches	Sleep Disorder	
Neurological	Dental	Swallowing Disorder	
Arthritis	Visual	Other	
Fractures	Communicable/Infectious Diseases		

Have you had any falls this year? Yes No If yes, please describe ____

Do you have a pacemaker? Yes No Metal Implants? Yes No

Are you or could you be pregnant at this time? Yes No

Surgeries: list type and date ____

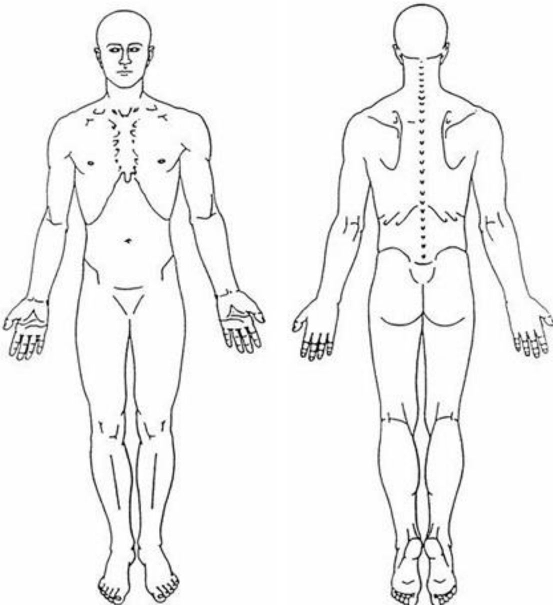
____

Have you ever received Physical, Occupational or Speech Therapy? Yes No

If so, for what type of problem? ____

What are your goals for treatment? ____

Are there any other considerations that your therapist should know? ____



Please mark the area of pain

Area and Behavior of Pain:

Initial site of pain ______________________________

Where is the pain now? _________________________
(See diagram at left)

Rate your pain by circling a number:

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain Possible

PATIENT SIGNATURE ___________________________________

DATE ____