LAKESIDE MANUAL PHYSICAL THERAPY
9445 ZACHARY TAYLOR HWY.
UNIONVILLE, VA 22567-0369
TEL: 540-854-0367 FX:540-854-0369

HEALTH HISTORY QUESTIONNAIRE

PATIENT'S FULL LEGAL NAME:_____DATE:_____

OCCUPATION: _____

LEISURE ACTIVITIES: _____

_____

LIST ANY MEDICATIONS YOU ARE ALLERGIC TO: _____

_____

_____

LIST ANY OTHER ALLERGIES WE SHOULD KNOW ABOUT: _____

_____

_____

ARE YOU LATEX SENSITIVE? YES NO

HAVE YOU DECLARED THE ADVANCED CLINICAL DIRECTION OF "DO NOT RESUSITATE?" YES NO

PLEASE CHECK ANY OF THE FOLLOWING WHOSE CARE YOU ARE CURRENTLY UNDER:

_____MEDICAL DOCTOR (MD)

_____PSYCHIATRIST/PSYCHOLOGIST

_____OSTEOPATH

_____PHYSICAL THERAPIST

_____DENTIST

_____CHIROPRACTOR

_____OTHER:_____

IF YOU HAVE SEEN ANY OF THE ABOVE DURING THE PAST THREE MONTHS, PLEASE DESCRIBE FOR WHAT REASON (ILLNESS, MEDICAL CONDITION, PHYSICAL, ETC._____

_____

_____

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PLEASE LIST ANY SURGERIES OR OTHER CONDITIONS FOR WHICH YOU HAVE BEEN HOSPITALIZED, INCUDING THE APPROXIMATE DATE AND REASON FOR THE SURGERY OR HOSPITALIZATION.

DATE	REASON FOR SURGERY/HOSPITALIZATION
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PLEASE DESCRIBE ANY SIGNIFICANT INJURIES FOR WHICH YOU HAVE BEEN TREATED (including fractures, dislocations, sprains)

DATE	INJURY
_____	_____
_____	_____
_____	_____
_____	_____

HAS ANYONEI N YOUR IMMEDIATE FAMILY (parents, brothers, sisters) EVER BEEN TREATED FOR ANY OF THE FOLLOWING? (Check all that apply)

_____DIABETES
_____HEART DISEASE
_____STROKE
_____CHEMICAL DEPENDENCY
_____ARTHRITIS
_____HEADACHES
_____MENTAL ILLNESS
_____TUBERCULOSIS
_____HIGH BLOOD PRESSURE
_____KIDNEY DISEASE
_____CANCER
_____ANEMIA
_____EPILEPSY

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HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS? Check all that apply

_____CANCER (if so, what type: _____)

_____HEART PROBLEMS

_____HIGH BLOOD PRESSURE

_____CIRCULATION PROBLEMS

_____ASTHMA

_____EMPHYSEMA/BRONCHITIS

_____CHEMICAL DEPENDENCY (i.e., alcoholism)

_____THYROID PROBLEMS

_____DIABETES

_____MULTIPLE SCLEROSIS

_____RHEUMATOID ARTHRITIS

_____OTHER ARTHRITIC CONDITIONS

_____DEPRESSION

_____HEPATITIS

_____TUBERCULOSIS

_____STROKE

_____KIDNEY DISEASE

_____ANEMIA

_____EPILEPSY

_____OTHER please explain:

_____

_____

DURING THE PAST MONTH HAVE YOU BEEN FEELING DOWN, DEPRESSED OR HOPELESS? YES NO

DURING THE PAST MONTH HAVE YOU BEEN BOTHERED BY HAVING LITTLE INTEREST OR PLEASURE IN DOING THINGS YOU NORMALLY ENJOY? YES NO

DO YOU FEEL UNSAFE AT HOME OR HAS ANYONE HIT YOU OR TRIED TO INJURE YOU IN ANY WAY? YES NO

FOR WOMEN: ARE YOU CURRENTLY PREGNANT OR THINK YOU MAY BE PREGNANCY? YES NO

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WHICH OF THE FOLLOWNG OVER-THE-COUNTER MEDICATIONS HAVE YOU TAKEN IN THE LAST WEEK?

(Check all that apply)

_____ASPIRIN
_____TYLENOL
_____IBUPROFEN
_____LAXATIVES
_____DECONGESTANTS
_____ANTIHISTAMINES
_____ANTACIDS
_____VITAMINS/MINERALS
_____OTHER: _____

PLEASE LIST ALL PRESCRIPTION MEDICATIONS YOU ARE TAKING, INCLUDING PILLS, INJECTIONS, AND/OR SKIN PATCHES:

1. _____ Dosage: _____ 2. _____ Dosage: _____
3. _____ Dosage: _____ 4. _____ Dosage: _____
5. _____ Doseage: _____ 6. _____ Dosage: _____

HOW MANY CAFFEINATED COFFEE OR CAFFEINE CONTAINING BEVERAGES DO YOU DRINK PER DAY? _____

HOW MANY PACKS OF CIGARETTES DO YOU SMOKE A DAY? _____

HOW MANY DAYS PER WEEK DO YOU DRINK ALCOHOL? _____

IF ONE DRINK EQUALS ONE BEER OR GLASS OF WINE, HOW MANY DRINKS DO YOU HAVE AT AN AVERAGE SITTING? _____

HAVE YOU RECENTLY NOTED ANY OF THE FOLLOWING? (Check all that apply).

_____WEIGHT LOSS/GAIN
_____NAUSEA/VOMITTING
_____DIZZINESS/LIGHTHEADEDNESS
_____FATIGUE
_____WEAKNESS
_____FEVER/CHILLS/SWEATS
_____NUMBNESS/TINGLING

_____ _____

Patient signature Date Therapist signature Date