PEAK PERFORMANCE
PHYSICAL THERAPY & SPORTS TRAINING

Medical History Questionnaire

Patient Name		**Date of Birth**		**Age**	
Reason for Therapy		**Date of Injury or Onset**			

Are you **currently** receiving any other care for the condition mentioned above? ☐ No ☐ Yes If yes, please list:

Have you ever received therapy **in the past** for the condition mentioned above? ☐ No ☐ Yes If so, when?

Previous Treatment Received:		Previous Treatment: ☐ Successful ☐ Unsuccessful

Have you received therapy services for **other problems/conditions this calendar year?** ☐ No ☐ Yes If yes, please list:

Can you be or are you pregnant? ☐ **No** ☐ **Yes**

Do you now or have you ever had any of the following conditions?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Arthritis	☐	☐	**Diabetes**	☐	☐	**Numbness/Tingling**	☐	☐
Osteoporosis	☐	☐	**Anemia**	☐	☐	**Fever/Chills**	☐	☐
High Blood Pressure	☐	☐	**Hypersensitivity to Heat/Cold**	☐	☐	**Thyroid Problems**	☐	☐
Heart Disease	☐	☐	**Swelling In Ankles**	☐	☐	**Headaches**	☐	☐
Heart Attack	☐	☐	**Deep Vein Thrombosis (DVT)**	☐	☐	**Head Injury/Concussion**	☐	☐
Pacemaker	☐	☐	**Seizures/Epilepsy**	☐	☐	**Hernia**	☐	☐
Vascular Disease	☐	☐	**Metal in Body or Surgical Implants**	☐	☐	**Kidney/Bladder Problems**	☐	☐
Stroke	☐	☐	**Cancer/Tumor**	☐	☐	**Previous Fractures**	☐	☐
Asthma	☐	☐	**Recent Weight Loss or Gain**	☐	☐	**Previous Surgeries**	☐	☐
Shortness of Breath	☐	☐	**Fatigue/Weakness**	☐	☐	**Hearing Loss**	☐	☐
Chronic Cough	☐	☐	**Tuberculosis**	☐	☐	**Depression**	☐	☐
Dizziness/Light Headedness /Fainting Spells	☐	☐	**Recurrent Infection(s) or Infection in the past 3 months**	☐	☐	**Anxiety**	☐	☐
Nausea/Vomiting	☐	☐	**Hepatitis**	☐	☐	**Substance Abuse**	☐	☐

If you answered "yes" on any of the above or have other conditions not listed, please explain and give approximate date(s):

Do you have any allergies? ☐ No ☐ Yes, list allergies:

Are you presently taking any medications? ☐ No ☐ Yes, list medications and specify condition:

At the present time, would you say that your health is (circle one): Excellent Very Good Fair Poor

The Information is correct to the best of my knowledge.

X	
Patient/Parent/Guardian Signature	Date