ProKinetics
PHYSICAL THERAPY

MEDICAL HISTORY QUESTIONAIRRE

Patient Name_____ **Referring Physician**_____
Primary Physician_____ **Last Health Check-Up**_____ **Did you have surgery for this injury?** ☐
Name of surgery:_____ **Date**_____

Are you currently taking prescription or non-prescription medication? *Please List*

_____
_____
_____

Have you had any Medical/Rehabilitative Care for this Injury/Episode? Please check the corresponding box

CHIROPRACTIC	☐	CT SCAN	☐
GENERAL PRACTITIONER	☐	X-RAY	☐
OCCUPATIONAL THERAPY	☐	MRI	☐
MASSAGE THERAPY	☐	ER CARE	☐
ORTHOPEDIST	☐	EMG/NVC	☐
NEUROLOGIST	☐	MYELOGRAM	☐
OBSTETRICIAN/GYNECOLOGIST	☐	PODIATRIST	☐
PEDIATRICIAN	☐	ACUPUNCTURIST	☐

Do you now have or have you ever had any of the following conditions? Please check the corresponding box.

ASTHMA/BRONCHITIS/EMPHYSEMA	☐	SEVERE OR FREQUENT HEADACHES	☐
SHORTNESS OF BREATH/CHEST PAIN	☐	VISION OR HEARING DIFFICULTY	☐
CORONARY HEART DISEASE/ANGINA	☐	NUMBNESS OR TINGLING	☐
PACEMAKER	☐	DIZZINESS OR FAINTING	☐
HIGH BLOOD PRESSURE	☐	WEAKNESS	☐
HEART ATTACK/HEART SURGERY	☐	WEIGHT LOSS/ENERGY LOSS	☐
BLOOD CLOT/EMBOLI	☐	HERNIA	☐
STROKE/TIA Date: ____/____/____	☐	EPILEPSY SEIZURES	☐
ALLERGIES Type_____	☐	THYROID TROUBLE/GOITER	☐
DIABETES	☐	BOWEL/BLADDER PROBLEMS	☐
INFECTIOUS DISEASE	☐	SLEEPING PROBLEMS	☐
CANCER Type: _____	☐	DO YOU SMOKE?	☐
CHEMO/RADIATION Date: ____/___/___	☐	ALCOHOL ABUSE	☐
OSTEOPOROSIS	☐	SUBSTANCE ABUSE	☐
LATEX ALLERGY/SENSITIVITY	☐	NECK INJURY/SURGERY	☐
DIASTASIS RECTI	☐	SHOULDER INJURY/SURGERY	☐
ARTHRITIS/SWOLLEN JOINTS	☐	ELBOW/HAND INJURY/SURGERY	☐
MULTIPLE SCLEROSIS	☐	BACK INJURY/SURGERY	☐
JOINT REPLACEMENT Date: ___/___/___	☐	KNEE INJURY/SURGERY	☐
PINS/METAL IMPLANTS: _____	☐	LEG/ANKLE/FOOT INJURY/SURGERY	☐

OTHER:_____

WOMEN ONLY

ARE YOU PREGNANT?	☐	PROLAPSE Type: _____	☐
COMPLICATED PREGNANCY/DELIVERY	☐	ENDOMETRIOSIS	☐
PELVIC INFLAMMATORY DISEASE	☐	IRREGULAR MENSTRUAL CYCLE	☐

FAMILY HISTORY
Please describe any illness or disease in your family.

_____
_____
_____
_____

Patient Signature:_____ **Date:**____/____/_____
Guardian Signature:_____**Date:**____/____/_____
Physical Therapist Signature:_____**Date:**____/____/_____