

Patient Health History Questionnaire

Patient Name _____ Age _____ Date _____

Diagnosis / Injury _____ Physician _____

If you ever had a listed condition in the past, please check it in the **PAST** column. If you are presently troubled by a particular condition, please check it in the **PRESENT** column. This information concerning past and present conditions and diseases assist your therapist in a more thoroughly understanding your state of health

PAST PRESENT

- | | | |
|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina / Chest Pains |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/Aids |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer – Location _____ Date _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Tumor |
| <input type="checkbox"/> | <input type="checkbox"/> | Systemic Lupus |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco Packs/day _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug and/or Alcohol Dependence |

Medications: _____

Allergies: _____

Hospitalization/Surgical Procedures: _____

Patient's Signature _____ Date _____

Therapist Notes _____