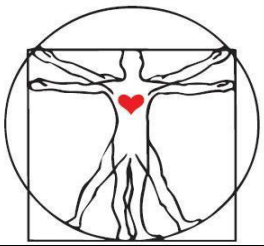

Temple Physical Therapy

230 George Street, 5th Floor
New Haven, Connecticut 06510
203.498.5980 Phone
203.498.5999 Fax

Health Questionnaire

Thank you for completing this form. It will help us to develop a safe treatment program.

Name: _____ Age: _____ Date: _____

Please list all current medications (may use back of form if needed):

Medication Name (Dose if known):	**Prescribed for:**
1.	
2.	
3.	
4.	
5.	
6.	

Do you smoke? Yes No Packs per day: _____ Drink Alcohol? Yes No How often? _____

Awareness of Diagnosis: _____ unaware _____ somewhat aware _____ fully aware

Awareness of Prognosis: _____ unaware _____ somewhat aware _____ fully aware

So you know the expected frequency and duration of treatment? Yes No _____ x/wk x _____ wks

PAST HISTORY: Please check if you ever had any of the following:

	YES	NO		YES	NO
Rheumatic Fever			Cancer (Type) _____		
Chest Pain			Emotional Disorders		
Heart Attack			Jaw Pain		
Heart Disease			Thyroid Disease		
High Blood Pressure			Colitis		
Controlled with: Meds:		Diet:	Ulcers		
Anemia/Blood Disorder			Gallbladder Disease		
Kidney/Bladder Disease			Frequent Fainting/Dizziness		
Gout			Infectious Diseases:		
Hernia			Chicken Pox		
Lung Conditions			Measles		
Inhaler required			Hepatitis		
Inhaler carried			Herpes		
Diabetes x____yrs			Allergies (Please list on back)		
Controlled with: Meds:		Diet:	Latex		
			Seasonal		
			Food		

Please list any other medical conditions: _____

Hospitalizations and/or and Serious Injuries

Explain Date

1. _____
2. _____
3. _____
4. _____

Surgical Procedures

Procedure Date

1. _____
2. _____
3. _____
4. _____

Signature: _____ Date: _____