HEALTH HISTORY

Patient: _____ Age: _____Disability: _____

Medical Doctor: _____ Tel: _____

Allergies: _____ Hearing Aids: _____

Epilepsy: _____ Diabetes: _____ Blood Pressure: _____

Do you have any illness? _____

Have you been hospitalized, or had surgery in the last 5 years? _____

Reason?_____

Please list any drugs or medication you are taking and the purpose of each one:

_____

Have you used cortisone / steroids in the last year? _____

Osteoporosis? _____ Osteo-arthritis? _____ Arthritis? _____

Are you on warfarin/blood thinning medication? _____

Are you pregnant?_____: _____Weeks. Do you have a pacemaker? _____

Do you have artificial joints or metal pins and plates? _____

Have you had excessive weight loss in the last few months? _____

Cancer? _____HIV+? _____

Do you have night pain; wake up in night with pain? _____

How many hours do you sleep per night? _____

Do you have sinus problems/hay fever / asthma? _____

Lung disorder? _____Headaches/Dizziness? _____

Do you smoke? _____ Any addictions? _____If yes -why? _____

Have things been dropping out of your hands? _____

Do your feet drag when you walk? _____

Any leg pain? _____ Any arm pain? _____

Any pins and needles (funny feelings) in arms? _____ or legs? _____

Do you have problems urinating?_____ or with bowel movements? _____

Do you have lots of stress? _____ What do you do with your stress? _____

What do you do for fun? _____

Would you say you have a balanced life? _____

What exercises / sport do you do? _____

Do you eat healthy / balanced? _____

Comments: _____

_____	_____	_____
Patient Signature	**Date**	**Physiotherapist Signature**