Medical History Form

Please answer the following questions to the best of your ability. The form can be filled out online or printed out. Once the form has been completed, email it to jana@diazpt.com or have it available for review at the time of your appointment.

Reason for visit:

What would you like to achieve with your session(s)?

Mark the appropriate box if YOU have a history of any of the following:

- ☐ High Blood Pressure
- ☐ Angina/Chest Pain
- ☐ Heart Disease
- ☐ Stroke
- ☐ High Cholesterol Levels
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Cancer
- ☐ Hepatitis/HIV
- ☐ Seizures
- ☐ Headaches
- ☐ Depression

Mark the appropriate box if YOU have experienced any of the following in the PAST THREE (3) MONTHS:

- ☐ Significant change in your health
- ☐ Shortness of breath
- ☐ Dizziness
- ☐ Fever/Chills/Sweats
- ☐ Numbness/Tingling
- ☐ Nausea/Vomitting
- ☐ Unexplained weight change
- ☐ Change in appetite
- ☐ Change in bowel/bladder
- ☐ Upper respiratory infection
- ☐ Chest pains
- ☐ Loss of consciousness
- ☐ Surgery

If any of the above are marked, please describe:

Did anyone in your immediate FAMILY (parents/siblings/children) have a history of heart attack, angioplasty, coronary artery bypass surgery or die suddenly? ○ yes ○ no

If yes, what was the age of onset or death?

Do you smoke tobacco or quit smoking in the past six months? ○ yes ○ no

Are you currently pregnant? ○ yes ○ no

Mark the box that most accurately describes you:

- ☐ Male or Female ≤44 years old
- ☐ Female 45-55 years old
- ☐ Male 45-69 years old
- ☐ Female 55-69 years old
- ☐ Male or Female ≥70 years old

In the PAST THREE (3) MONTHS, about how much time in an average WEEK did you spend performing any of the following activities (or similar): brisk walking, swimming, jogging, running, social tennis, cleaning windows/car, aerobics, heavy yard work

- ☐ 0-30 mins/week
- ☐ 30-70 mins/week
- ☐ 70-150 mins/week
- ☐ 150-300 mins/week
- ☐ 300+ mins/week

I currently have difficulty with the following daily activities as a result of my current condition:

- ☐ standing
- ☐ walking
- ☐ sitting
- ☐ bending
- ☐ lifting
- ☐ reaching overhead
- ☐ sleeping
- ☐ reaching behind my back
- ☐ driving
- ☐ dressing/grooming
- ☐ grasping
- ☐ getting up from chair
- ☐ using stairs
- ☐ work activities

Other:

Mark all that apply:

- ☐ I have fallen in the past year
- ☐ I use or have been advised to use a cane or walker to get around safely
- ☐ Sometimes I feel unsteady when I am walking
- ☐ I steady myself by holding onto furniture when walking at home
- ☐ I am worried about falling
- ☐ I need to push with my hands to stand up from a chair
- ☐ I have some trouble stepping up onto a curb
- ☐ I often have to rush to the toilet
- ☐ I have lost some feeling in my feet
- ☐ I take medicine that sometimes makes me feel light-headed or more tired than usual
- ☐ I take medicine to help me sleep or improve my mood
- ☐ I often feel sad or depressed

Which of the following treatments have you tried for your current condition:

- ☐ Chiropractic
- ☐ Physical Therapy
- ☐ Injections
- ☐ Massage
- ☐ Heat/Cold
- ☐ Pain medicine
- ☐ Anti-inflammatory medicine
- ☐ Muscle relaxers
- ☐ Alternative/Homeopathic medicine

Results/Comments:

Which of the following diagnostic test have you had for your current condition:

- ☐ MRI
- ☐ X-ray
- ☐ CT Scan
- ☐ Bone Scan
- ☐ EMG

Results/Comments: