## Health Questionnaire

Name: ________________________________ Date of Birth: _____/_____/_____

Email: ________________________________

Why are you coming to Functional Physical Therapy?

- ❏ Physical Therapy
- ❏ Sports Performance

Do you have a specific diagnosis or body part that we should be focusing on? ____________

**Previous Experiences:**

Have you ever had physical therapy before? _____ No _____ Yes
Did you get the results that you were expecting from it? _____ N/A _____ No _____ Yes

Have you ever been to a personal trainer or sports performance expert? _____ No _____ Yes
Did you get the results that you were expecting from it? _____ N/A _____ No _____ Yes

How do you rate your overall health? __ Excellent __ Good __ Fair __ Poor
How do you rate your overall level of activity? __ Very Active __ Active __ Fair __ Poor
How often are you exercises at least 30 minutes?_Everyday _Most Days _Inconsistent _ Never
How often are you on a screen (computer, phone, TV)? __Not Much __ On/Off __Frequent
How much are you restricted by pain? __ No pain __ Minimally __ Moderately __ Severely
Do you experience pain at night? __ No pain __ Rarely __ Sometimes __ Often
Do you typically get a good night's sleep? __ Yes __ Often __ Sometimes __ Never
Do you wake up sweating at night? __ Never __ Rarely __ Sometimes __ Often
How do you describe your typical food choices? __ Healthy __ Good __ Fair __ Poor
On a typical day, how many glasses of water do you drink? __ None __ 1-2 __ 3-5 __ 6-8+
In a typical week, how many alcoholic drinks do you consume? __ 0-2 __ 3-7 __ 8-14 __ 15+
How much weight have you gained the past year? __ None __ 1-5 lbs __5-9 lbs __ 10+ lbs
How much weight have you lost the past year? __ None __ 1-5 lbs __5-9 lbs __ 10+ lbs
If you lost weight, has it been intentional (new diet, exercise)? __N/A __ Yes __ Not Sure __ No
Do you smoke cigarettes or use tobacco? __ Never __ Rarely __ Socially __ Often
Any new (or growing) moles on your body or head? __ No __ Not Sure __ Possibly __ Yes
Are you pregnant? __ N/A __ No __ Possibly __ Yes
How often do you feel down, depressed, or hopeless? __ Never __ Rarely __Sometimes _Often

## Health Questionnaire

**Medical History:** (check all that apply)

| | | | |
|---|---|---|---|
| ______ Allergies | ______ Chest Pain | ______ Fractures | ______ Pneumonia |
| ______ Anemia | ______ Chronic fatigue | ______ Frequent Infection | ___ Psychiatric Hx |
| ______ Asthma | ______ Circulation issues | ______ Frequent Urination | _____ Seizures |
| ______ Bladder Problems | _____ Concussion | ______ Headaches | ___ Skin Conditions |
| ______ Blood Clots | ______ Constipation | ______ Heart Attack | ______ GI Issues |
| ______ Bowel Problems | ______ Depression | ______ High BP | _____ Panic Attacks |
| ______ Brain Injury | ______ Diabetes | ______ Incontinence | ______ Stroke |
| ______ Cancer | ______ Ear Infections | ______ Low BP | ______ UTI |
| ______ Cardiac Issues | ______ Fibromyalgia | ______ Pacemaker | |

*Any other medical conditions:*

_______________________________________________________

**Surgeries:** (list all procedures throughout your lifetime)

_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________

**Medications & Supplements:** (list all taken over the past year)

_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________

**Emergency Contact:** Name: ___________________________ Phone: _____________________

Relationship to you: _________________________

**By signing below, I attest that the statements above are true to the best of my knowledge.**

| | |
|---|---|
| **Your Signature/ Guardian's Signature** | **Date** |

Client Name: ________________________Guardian's Name (if applicable): ________________