LIBRA PHYSICAL THERAPY

NEW EVALUATION HEALTH QUESTIONNAIRE

8526 N Canton Center Rd.
Canton, MI 48187
(734) 404-5856
libraphysicaltherapy@gmail.com

Date: _____

Name: _____ DOB: _____/_____/_____ SS# _____/_____/_____

Home Phone # ( ) _____-_____ Cell # ( ) _____-_____ Work # ( ) _____-_____

Street: _____City:_____State:_____Zip:_____

Email Address: (Please print neatly):_____

Your email is for internal use only and will not be sold to third parties

Do we have permission to contact you by email? Yes_____No_____

Occupation: _____Referring Physicians _____

Emergency Contact's Ph# ( )_____/_____ Relationship: _____

Insurance Cardholder's Name: _____ DOB: _____/_____ /_____

Have you ever had or been told you had any of the following: (Check if yes)

- ___ Cardiovascular Disease
- ___ High Blood Pressure
- ___ Respiratory Disease
- ___ Cancer
- ___ Pelvic Floor Dysfunction (incontinence/pain)
- ___ Unexplained weight loss
- ___ Diabetes Type I or Type II
- ___ Varicose veins
- ___ Epilepsy
- ___ Birth defect of any type
- ___ Gout
- ___ Chest pains
- ___ Gastrointestinal Disease
- ___ Neurological Disorder
- ___ Rheumatoid arthritis
- ___ Depression
- ___ Osteoarthritis
- ___ Allergies
- ___ Kidney Disease
- ___ Other:_____

Explain if yes:

_____

_____

List all hospitalizations: Operations, serious illness, injuries, etc.

_____

_____

Your present weight: _____ height: _____

Are you pregnant? _____ **Do you currently have any illnesses? _____**

Please describe your activity level prior to this injury/condition:

_____

_____

List all your current medications: (Prescription, over the counter, vitamins & herbal):

NAME	DOSE	FREQUENCY

What is the reason for seeking therapy at this present time?

_____

_____

What type of diagnostic testing have you had for this condition: (Examples: MRI, x-rays)

_____

_____

_____

Have you ever had therapy in the past for tis injury / condition? If so, when?

_____

_____

Please rate your level of pain on a 0 – 10 scale:

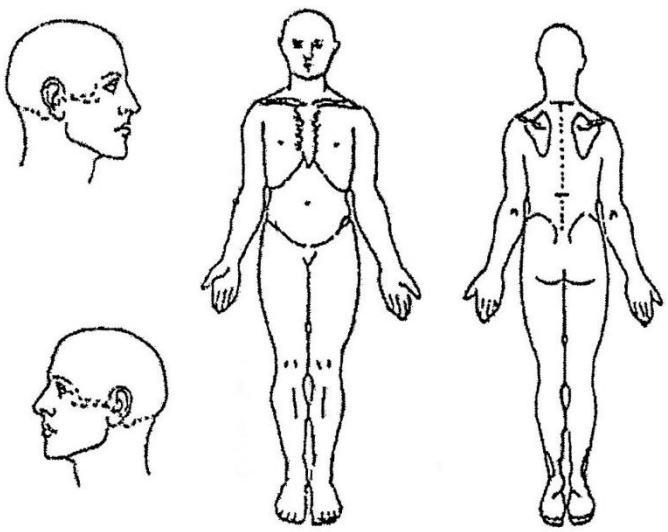
Rate your pain:

At worst: _____

At best: _____

Current: _____

Mark areas of pain on body diagram:



I certify that the above information is true and accurate to the best of my knowledge.

Signature: _____ **Date: _____**