Pro-Activities, LLC Past Medical History Questionnaire

Patient Name:	Date of Birth:
Reason for therapy:	Date of Injury or Onset:
Have you ever received therapy for the condition mentioned above? ☐Yes ☐No	If so, when?
Treatment Received:	Was previous treatment successful? ☐Yes ☐No
Are you pregnant? ☐Yes ☐No	

Do you now or have you ever had any of the following?

	Yes	No		Yes	No		Yes	No
Arthritis			Diabetes			Thyroid Problems		
Osteoporosis			Anemia			Headaches		
High Blood Pressure			Hypersensitivity to Heat/Cold			Head Injury/Concussion		
Heart Disease			Swelling in Ankles			Hernia		
Heart Attack			Deep Vein Thrombosis (DVT)			Kidney/Bladder Problems		
Pacemaker			Seizures/Epilepsy			Previous Fractures		
Vascular Disease			Metal in Body or Surgical Implants			Previous Surgeries		
Stroke			Cancer/Tumor			Hearing Loss		
Asthma			Recent Weight Loss or Gain			Depression		
Shortness of Breath			Current Infection(s)			Anxiety		
Chronic Cough			Tuberculosis			Substance Abuse		
Fainting Spells			Hepatitis			Other		

If you answered “yes” to any of the above, please explain and give approximate date(s):

Do you have any allergies: ☐No ☐Yes, list allergies:

Are you presently taking any medications? ☐No ☐Yes, list medications and specify condition:

This information is correct to the best of my knowledge.

Patient/Parent/Guardian Signature	Date
Therapist Signature	Date