Fairplay Therapy Center

HEALTH HISTORY

Please list any medications you take – both prescription and over-the-counter medications: _____

_____

_____

Please list any serious injuries you have had in the last 10 years:	**Description**	**Date**
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Other	_____	_____

Women: Are you pregnant? Yes/No **If so, how far along?** _____ **Nursing?** Yes/No

MEDICAL CONDITIONS

Circle "Y"(Yes) or "N"(No) for each medical condition you have had in the past or currently have:

Y/N Heart Attack/Stroke	Y/N Arthritis	Y/N Ringing in ears	Y/N Ulcer/Colitis
Y/N Congenital Heart Defects	Y/N Frequent Neck Pain	Y/N Freq Headaches	Y/N Gout
Y/N Alcohol/Drug Abuse	Y/N Jaw Pain	Y/N Diabetes/TB	Y/N Numbness
Y/N Fainting/Seizures	Y/N Wrist Pain	Y/N Dizziness	Where? _____
Y/N Shingles	Y/N Shoulder Pain	Y/N Emphysema	Y/N Tingling
Y/N Psychiatric Issues	Y/N Arm Pain	Y/N Kidney Problems	Where? _____
Y/N Difficulty Breathing	Y/N Leg Pain	Y/N Artificial bones/joints	Y/N Muscle/Spasms
Y/N Hepatitis	Y/N Lower Back Pain	Y/N Cancer	Where? _____
Y/N Anemia	Y/N Frequent Earaches	Y/N HIV Positive/Aids	

PERSONAL HABITS

Do you drink alcohol? Y/N If so, how much? _____
Do you drink coffee? Y/N If so, how much? _____
Do you smoke? Y/N If so, how many? _____
Do you exercise? Y/N If so, how much? _____
How many hours of sleep do you regularly get each night? _____
Is your appetite regularly: Poor? Typical? Excessive?

Do you have any known allergies to food, medications or other substances? Yes/No **If "Yes", please list:**

_____

_____

AUTHORIZATON

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the physical therapist to help determine appropriate and healthful physical therapy treatment. If there is any change in my medical status, I will inform the physical therapist.

I authorize Fairplay Therapy Center to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ **Today's Date**: _____
Printed Name: _____ **Date of Birth:** _____