ProActive Physical Therapy, LLC

"Be ProActive, Not ReActive"

Patient Health History Questionnaire

Name: ____ **Date**: ________________________

DOB: **Age:** **Height:** **Weight:**

Have you ever been diagnosed with any of the following :

☐ Diabetes ☐ Osteoporosis ☐ Hyperthyroid ☐ Heart Condition ☐ Bowel Changes
☐ Dizziness ☐ Osteopenia ☐ Hypothyroid ☐ Pacemaker ☐ Bladder Changes
☐ Arthritis ☐ Epilepsy ☐ Cancer ☐ Vascular Disease ☐ Tuberculosis
☐ Hepatitis ☐ COPD ☐ Weight Loss ☐ Head Injury ☐ Stroke
☐ Depression ☐ Anemia ☐ Respiratory Problems

Have you fallen in the last two years: Yes No

Women Only: Pregnant Births Pelvic Pain Menstrual Pain

Dominate side: Right Left

Occupation: ____

Surgeries

Year	Reason

Hospitalizations

Year	Reason

Do you drink caffeinated coffee/beverages: ☐ **Yes** ☐ **No**

How much caffeinated coffee/beverages do you drink per day? ________________________________

Do you smoke: ☐ **Yes** ☐ **No**

How many packs of cigarettes do you smoke a day? ________________________________

How many days per week do you use/drink:

Alcohol ____________________________ How much do you drink at an average sitting? _________

Marijuna ___________________________