Medical History Questionnaire

Name_____ Date of Birth_____
Allergies_____

1. What is your reason for seeking Therapy today?
   _____
   _____
2. List all medications you are currently taking.
   _____
   _____
3. What supplements/vitamins do you take?
   _____
   _____
   Would you be interested in getting assistance with this? Y / N
4. Do you currently use shoe inserts or orthotics?
   _____
5. List past surgeries relevant to the current problem and any hospitalizations in the past year.
   _____
   _____
6. Any other Treatments for the current problem? If yes, what were they?
   _____
   _____
7. Do you have any other diagnoses or problems that may inhibit or prevent you from participating fully in a rehab program, including exercise?
   _____
   _____
8. What are your goals to achieve with Performance Lifestyles?
   _____
   _____

Some illnesses and conditions are genetically transferred. It is useful for us to know what conditions you or your family members have or have had in the past. Please tell us:

Condition	*I Had*	*When*	*Family (Specify)*	*When*
Arthritis	____	____	___ _____	____
Rheumatism	____	____	___ _____	____
Back Problems	____	____	___ _____	____
Neck Problems	____	____	___ _____	____
Sprain/ Strain	____	____	___ _____	____
Headaches	____	____	___ _____	____
Hand Problem	____	____	___ _____	____
Knee Pain	____	____	___ _____	____
Hip Pain	____	____	___ _____	____
Ankle Pain	____	____	___ _____	____