ProIMPACT
Physical Therapy & Sports Performance

MEDICAL HISTORY QUESTIONNAIRE

Patient Name:	Age:	Date of Injury/Onset:
Are you **currently** receiving any other care for the condition mentioned above? ☐ No ☐ Yes- If Yes, please list:		
Have you ever received therapy **in the past** for the condition mentioned above? ☐ No ☐ Yes		If so, when?
Have you received therapy services for **other problems/conditions during the current year?** ☐ No ☐ Yes- If Yes, please list:		
Could you be or are you pregnant? ☐ No ☐ Yes	Do you have a pacemaker? ☐ No ☐ Yes	

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

Osteoporosis	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Seizures / Epilepsy	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Cancer / Tumor	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Hernia	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Dizziness/Lighheadedness / Fainting Spells	☐ Yes	☐ No	Metal in Body / Surgical Implants	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Recurrent Infections or infection in last 3 mos.	☐ Yes	☐ No
Previous Surgeries	☐ Yes*	☐ No			

*If Yes, please list:_____

_____

Do you have any allergies? ☐ No ☐ Yes- If Yes, please list:
Are you presently taking any medications? ☐ No ☐ Yes, list medications and specify condition:
This information is correct to the best of my knowledge.

X	
Patient / Parent / Guardian Signature	Date