Therapy Center of Cedar Point
Medical History Questionnaire

Name:_____
Birth Date:____/____/_____ **Age**:_____ **Occupation**:_____
Referring Physician:_____
Family Physician:_____ **Date of Last Check-up**:_____

Have you had surgery for the injury you are being seen for today? YES NO If yes, type of surgery/date:_____

Please circle any/all that apply to your personal health history:

AIDS/HIV	Vision/Hearing Difficulty	Angina/Coronary Artery Disease
Anemia	Arthritis/Swollen Joints	Bowel or Bladder Problems
Bronchitis	Blood Clot/Emboli	Cancer/Chemo/Radiation
Allergies	Congenital Heart Defect	Congestive Heart Failure
Asthma	Diabetes	Dizziness/Fainting
Chest Pain	Drug Abuse	Emphysema
Fainting	Epilepsy/Seizures	Frequent Headaches
Fractures	GERD/Reflux	Heart Attack
Hernia	Heart Murmur	Hepatitis
High Blood Pressure	Joint Replacement	Swelling of Hands/Feet
Kidney Disease	Infectious Disease	Multiple Sclerosis
Motor Vehicle Accident	Osteoporosis	Pins/Metal Implants
Parkinson's Disease	Pace Maker	Seizures
Shortness of Breath	Latex Allergy/Sensitivity	Sleeping Difficulty/Problems
Stroke/TIA	Weight Loss/Gain	MRSA

For women only:

Endometriosis Pelvic Inflammatory Disease Incontinence (urinary/fecal)
Complicated Pregnancies/Deliveries

Choose your type of pain by circling one or more of the following:

Constant Intermittent Sharp Dull Aching Stabbing Numbness Pins/Needles

Please draw a vertical line where you would rate your pain intensity:

0----------5----------10
No Pain Maximum Pain Tolerable

Are you taking any of the following medications:

{_}Anti-inflammatory {_}Muscle relaxers {_}Pain Medications
Please list all other current medications on the following page.

Signature:_____ **Date:**_____