ADI REHAB
incorporated
PHYSICAL THERAPY SERVICES

HEALTH QUESTIONNAIRE

PATIENT NAME: **DATE:**

PLEASE CHECK THE FOLLOWING THAT APPLY:

1. Fevers/chills/sweats	_____Yes	_____ No
2. Unexplained weight loss/gain	_____Yes	_____ No
3. Malaise (feeling generally unwell)	_____Yes	_____ No
4. Unusual fatigue	_____Yes	_____ No
5. Nausea/vomiting	_____Yes	_____ No
6. Numbness/tingling	_____Yes	_____ No
7. Weakness	_____Yes	_____ No
8. Dizziness/lightheadedness/loss of consciousness	_____Yes	_____ No
9. Chest pain/palpitations	_____Yes	_____ No
10. Swelling in feet/hands	_____Yes	_____ No
11. Difficulty breathing/shortness of breath	_____Yes	_____ No
12. Difficulty breathing when lying down	_____Yes	_____ No
13. Cough/change in cough/blood in phlegm	_____Yes	_____ No
14. Wheezing	_____Yes	_____ No
15. Difficulty swallowing	_____Yes	_____ No
16. Heartburn/Indigestion	_____Yes	_____ No
17. Change in appetite	_____Yes	_____ No
18. Specific food intolerance/nausea/vomiting	_____Yes	_____ No
19. Bowel pattern changes (color/texture/frequency)	_____Yes	_____ No
20. Difficulty urinating (starting/stopping	_____Yes	_____ No
21. Urine frequency changes	_____Yes	_____ No

Name all diagnosed medical conditions and surgeries either existing or in the past:

_____

Please check if you have the following conditions:

Diabetes	_____	High Blood Pressure	_____	Osteporosis	_____
Pacemaker	_____	Cancer/or History of Cancer	_____	Osteopenia	_____
Stroke	_____	Heart Condition (name)	_____		
Pregnancy	_____	Asthma	_____		

Please list any medications you are taking: _____

_____

Are you allergic to any medications? _____

Are you allergic to: Latex Yes/No Tape adhesive _____ Yes/No