Pilates MN Health History Questionnaire

NAME:				
Last	Fi	irst	МІ	
ADDRESS:				
Street	Ci	ity Sta	te Zipcode	
EMAIL:				
PHONE:	(Home)		(Cell)	
AGE:	<u></u>	DOB:	SEX: ○ M ○ F	
OCCUPATION:				
CURRENT CONDITION/CHIEF C	COMPLAINT:		DATE OF ONSET:	
			5/112 01 0110211	
EMPLOYMENT/WORK STATUS	•	so.	CIAL & HEALTH HABITS	
LIVII LOTIVILIVI / WORK STATOS	✓ Working PT outside		CIAL & HEALTH HABITS	
○ Working FT outside of home	_		Smoking Yes No	
○ Working FT from home	○ Working PT from h	ome	# packs/day	
○ Homemaker	○ Student	:	# cigars/pipes a day	
Retired	Unemployed		Smoked in past? O Yes O No	
		,	Year Quit	
GENERAL HEALTH STATUS				
Please rate your health:		b) <i>i</i>	Alcohol Yes O No	
○ Excellent ○ Good ○ Fair ○ Poor			Avg # days/week you drink	
			Avg # of drinks per day	
FAMILY HISTORY (and relation	ı to you)			
○ Heart Disease		c) I	Exercise Yes No	
Hypertension			Describe exercises beyond daily activities	
○ Stroke				
○ Diabetes				
○ Cancer			# days/week# minutes	
○ Psychological				
○ Arthritis				
Osteoporosis		Otl	Other Clinical Tests in Past Year	
○ Glaucoma			MRI Myelogram	
Orthopedic	-	$\overline{}$	CT Scan	
○ Neuropathy			NCV/EMG X-rays	
Scoliosis			Biopsy	
○ Incontinence	-		Bone Scan	
Other			Bone Density	
		()		

Arthritis	Seizures					
	Blood Disorders					
Fractures	_					
Growth Problems	Circulatory Problems					
Allergies	Heart Problems					
Thyroid Problems	High Blood Pressure					
Cancer	Cung Problems					
Infectious Diseases	_					
Kidney Problems						
Ulcers						
Skin Diseases		<u> </u>				
O Depression	Parkinson's Disease					
O Pacemaker	Other					
OTHER MEDICAL CARE - Are you seeing anyone els	e for your problem?					
FUNCTIONAL STATUS - Do you have difficulty:	O Deing on avound lavel	O Dathing or descripe				
Walking up stairsGetting in and out of bed	Being on ground levelWalking up or down inclines	Bathing or dressingWith house chores				
Getting in and out of bed Getting up from a chair	Walking up of down inclines	With house thores				
Getting up from a chair						
Have you ever had surgeries? Yes No Additional Comments:						
1) Date: Surgery:						
2) Date: Surgery:						
3) Date: Surgery:						
4) Date: Surgery:						
Within the past year, have you had these sympton	ns?					
Chest Pain	Opifficulty Swallowing					
Heart Palpitations	Bowel Problems					
Shortness of Breath	Urinary Problems					
O Dizziness/Blackouts		Headaches				
C Loss of Balance	_ ~	○ Vision Problems				
Generalized Weakness						
Difficulty Sleeping	Cough/hoarseness					
Nausea/Vomiting						
○ Weight loss/gain	Egyer chills/sweats	Fever chills/sweats				
Coordination Problems		☐ Joint pain or swelling				
	_					
Prescription Medications:						
Over the Counter Medications:						
Fitness Goals:						
Physical Therapy Goals:						
To the best of my knowledge, this information is correct and accurate:						