FOCUS
Physical Therapy
& Wellness

Medical History Questionnaire

Please note any past or current medical conditions you have experienced:

Allergies	Y	N	Fibromyalgia	Y	N
Anemia	Y	N	Fracture	Y	N
Anxiety	Y	N	Headaches	Y	N
Arthritis (Osteo or Rheumatoid)	Y	N	Hearing Impairment	Y	N
Asthma	Y	N	Hepatitis	Y	N
AutoImmune Disorder	Y	N	High Cholesterol	Y	N
Blood Pressure Issue (High or Low)	Y	N	HIV/AIDS	Y	N
Cancer	Y	N	Kidney Condition	Y	N
Cardiac Condition	Y	N	MRSA or C-Diff Infection	Y	N
Cardiac Pacemaker	Y	N	Multiple Sclerosis	Y	N
Circulation Issues	Y	N	Osteoporosis/Osteopenia	Y	N
Depression	Y	N	Seizures	Y	N
Diabetes: (Type 1 or Type 2)	Y	N	Stroke	Y	N
Dizziness	Y	N	Thyroid Disease	Y	N
Emphysema	Y	N	Vision Problems	Y	N

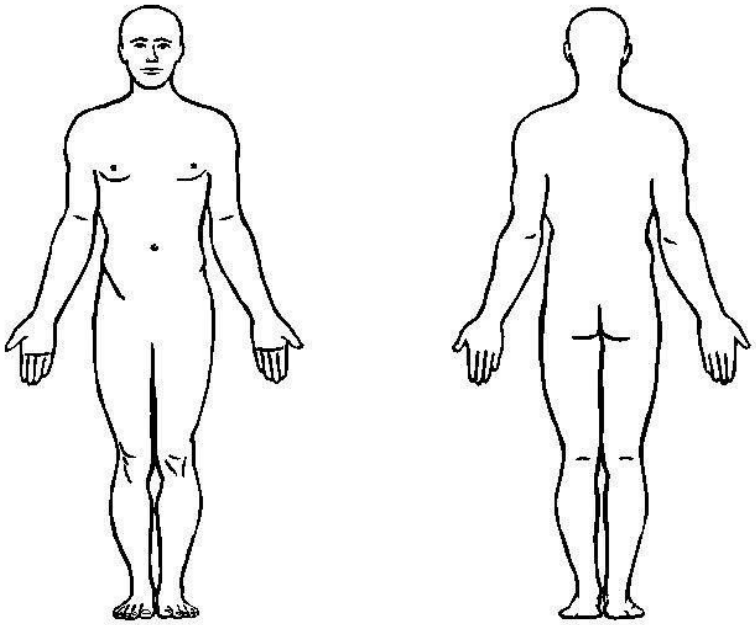
List any medications, vitamins, or supplements you are currently taking. Include dosage, frequency, and method (or provide a printed list):

1. _____ taken for _____
2. _____ taken for _____
3. _____ taken for _____
4. _____ taken for _____
5. _____ taken for _____

Please list any past surgeries:

1. _____ date: _____
2. _____ date: _____
3. _____ date: _____
4. _____ date: _____
5. _____ date: _____

Please mark where your symptoms are located on the body chart below:



Please include a description of the pain such as:

- Burning
- Tingling
- Numbness
- Sharp
- Aching

Please rate your current pain level from 0-10 (circle):

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Please include any other relevant information about your injury, current health status, or physical limitations: _____
_____
_____

Focus Physical Therapy & Wellness
803 W. Broad Street, Suite 330 Falls Church, VA 22046
(703) 457- 9876