Total Health Physical Therapy General Health Questionnaire

2142 W Railroad Ave, Suite A~Shelton, WA 98584~Phone (360) 426-0175

Name:_____Date:_____

Have you had a complete medical check-up in the past year? YES NO

Do you now have a contagious condition? YES NO If yes, please explain:_____

_____

Do you now have or have you recently had any of the following: (Please Check)

_____Shortness of breath
_____Pain or feeling of heaviness in your chest
_____Pulsating pain anywhere in your body (Please specify)_____
_____Constant and severe pain in your lower leg
_____Discolored or painful feet
_____Dizziness
_____Persistent pain at night
_____Constant pain anywhere in your body (Please specify)_____
_____Unexplained weight loss
_____Unusual lumps or growths (Please specify)_____
_____Constant fatigue
_____Frequent or severe abdominal pain
_____Frequent heartburn or indigestion
_____Bladder problems (Please specify)_____
_____Frequent nausea or vomiting
_____Change in bowel function (Please specify)_____
_____Unusual menstrual irregularities
_____Changes in hearing (Please specify)_____
_____Frequent or severe headaches
_____Problems with swallowing or changes in speech
_____Problems with vision (Please specify)_____
_____Problems with balance or falling
_____Fainting spells
_____Problems with coordination
_____Fever
_____Severe emotional disturbances
_____Swelling or redness in any joint (Please specify)_____
_____Are you pregnant? YES NO

Please list all of your current medications, including over-the-counter supplements:_____

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_____Revised 10-2015