

MEDICAL QUESTIONNAIRE



Kinesis Physical Therapy, LLC
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 www.kinesispts.com

Name: _____

Last

First

MI

Medical History

DO YOU HAVE ANY OF THE FOLLOWING:	YES	NO		YES	NO
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Parkinsons	<input type="checkbox"/>	<input type="checkbox"/>
Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Currently Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Strokes	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>
Have you fallen in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	Are you being threatened or hurt by anyone?	<input type="checkbox"/>	<input type="checkbox"/>

Describe any other Conditions or Precautions

Current Medications

	YES	NO		Date:
Is this a work related accident?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of injury:	
Is this injury a result of an auto accident?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of accident:	
Recent Surgery	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of surgery:	

Signature: _____

Date: _____

