Michigan THERAPY Institute
Quality, compassionate physical therapy for optimum results

Health Questionnaire

Patient Name: ______________________ Email: ______________________
Address: ______________________ City/State: ______________ Zip: __________
Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________
Social Security #: ______________ Birthdate: ______________ M / F (circle one)
Is the patient a minor child? ________ If so, name responsible party: ______________________

Emergency Contact:
Name: ______________________ Relationship: __________ Phone: ______________
Do we have permission to share information with this person? Yes ______ No ______

Treating Physician:
Name: ______________________ Phone: ______________
Address: ______________________ City/State: ______________ Zip: __________

Primary Care Physician: **same as above ____**
Name: ______________________ Phone: ______________
Address: ______________________ City/State: ______________ Zip: __________

Employment: Occupation ______________________
Are you presently working: ❑ Yes (please fill out below) ❑ No (last day worked) ______________
Employer: ______________________ Work Phone: ______________
Address: ______________________ City/State: ______________ Zip: __________

Medical History:
Have you ever been diagnosed with any of the following conditions? Please ✓

	Yes No		Yes No		Yes No
Cancer	❑ ❑	Heart Attack	❑ ❑	Anemia	❑ ❑
High Blood Pressure	❑ ❑	Chemical Dependency	❑ ❑	Disc Disease	❑ ❑
Asthma	❑ ❑	Depression	❑ ❑	Epilepsy	❑ ❑
Emphysema	❑ ❑	Rheumatoid Arthritis	❑ ❑	Kidney Disease	❑ ❑
Thyroid Problems	❑ ❑	Other Arthritic Cond.	❑ ❑	Arteriosclerosis	❑ ❑
Diabetes	❑ ❑	Hepatitis	❑ ❑	Tuberculosis	❑ ❑
Multiple Sclerosis	❑ ❑	High Cholesterol	❑ ❑	Osteoporosis	❑ ❑

Other: ______________________

Medications: 1. __________ 2. __________ 3. __________
4. __________ 5. __________ 6. __________
7. __________ 8. __________ 9. __________

Reason to be seen:
____

List any changes/symptoms that are affecting your daily activities since your injury, accident, surgery and/or illness.
____
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I have read the above and have completed the answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Patient's Signature: ______________________ ***Date:*** ______________