CULLMAN REGIONAL
Therapy Services

HEALTH HISTORY QUESTIONNAIRE

Email address: _____ (so that we may send you appointment reminders)

** **Have you been exposed to anyone with a fever, symptoms or a positive Covid test in the last 14 days? _____ Yes _____ No**

Are you experiencing/ have ever experienced any of the following:

Yes No

- ☐ ☐ Breathing problems/COPD
- ☐ ☐ High Blood Pressure/Heart problems/Pacemaker
- ☐ ☐ Dizziness/Fall in past 6 months
- ☐ ☐ Diabetes
- ☐ ☐ Spinal Injury / Back problems requiring medical attention
- ☐ ☐ Stroke/CVA/TIA
- ☐ ☐ Kidney issues/Loss of bowel or bladder control
- ☐ ☐ Joint replacement surgery
- ☐ ☐ Epilepsy/Seizure in past 6 months
- ☐ ☐ Head Injury/Memory Loss
- ☐ ☐ Multiple Sclerosis
- ☐ ☐ Arthritis/Pain in Joints/Fibromyalgia
- ☐ ☐ Dementia / Alzheimers
- ☐ ☐ Pregnancy (Due date:_____)
- ☐ ☐ Difficulty Swallowing*
- ☐ ☐ Mental illness/Depression
- ☐ ☐ Implanted electrical device / pain pump / mechanical device
- ☐ ☐ HIV/AIDS
- ☐ ☐ Cancer (location: _____)
- ☐ ☐ Osteoporosis/Osteopenia

Other: _____

** Please be prepared to pay your co-pay on each visit. This amount is determined by your insurance company for services received.

1. Please list current medications: (☐ copy provided and scanned) _____
   _____
   _____
2. Are you allergic to: Bee stings Yes / No Latex Yes / No Menthol products Yes / No
   Biofreeze Yes / No Cortisone Yes / No Cocoa Butter Yes / No
   Please list other allergies:_____
3. Have you ever had any surgeries? Yes / No If Yes, please list all previous surgeries:
   _____
   _____
4. Are you currently receiving any care at your home/residence from an outside agency? **Yes/No**. If yes, which agency?_____. **If you do not notify us if your status changes and we receive a denial from Medicare due to overlapping services, you will be responsible for payment of this bill.**
5. _____ _____ _____ _____

Patient Signature Height Weight Date