Osoyoos + South Okanagan
PHYSIOTHERAPY
AND ACTIVE WELLNESS CENTRE

GENERAL HEALTH QUESTIONNAIRE

Name (First): _____ (Last): _____ Date: _____ Age: ____

YES	NO	
		1. Has your doctor ever said that you have heart trouble? If yes...what? When?
		2. Do you frequently have pains in your heart and chest? If yes...how often?
		3. Do you have problems with the swelling of the lower extremities (legs)?
		4. Do you often feel faint or have spells of severe dizziness? How often?
		5. Have you ever been treated for any of the following conditions: ☐ heart disease ☐ high blood pressure ☐ low blood pressure ☐ tuberculosis ☐ kidney Disease ☐ cancer/malignancy ☐ liver disease/hepatitis ☐ skin problems ☐ epilepsy ☐ diabetes ☐ blood clots ☐ stroke ☐ hernia ☐ AIDS ☐ asthma ☐ emotional problems ☐ surgeries ☐ other:
		6. Has your doctor ever told you that you have a bone or joint problem, such as arthritis, that has been aggravated by exercise or might be made worse with exercise? If yes....specify:
		7. Is there a good physical reason why you should not follow an activity program even if you wanted to? If yes....specify:
		8. Do you experience difficulty breathing at rest?
		9. Do you have a persistent cough?
		10. Have you had a recent viral infection?
		11. Do you have any vascular/circulatory/blood vessel problems?
		12. FEMALES: Are you pregnant or think you may be pregnant?
		13. Are you receiving any other therapy or treatment at the present time? If yes....what kind:
		14. Do you have any metal in your body, such as: ☐ a pacemaker ☐ broken bones ☐ joint replacement ☐ an IUD (intrauterine device) ☐ shrapnel
		15. Are you taking any medications? Name of medication: ☐ cortisone pills/injections ☐ anti-inflammatory ☐ muscle relaxants ☐ sleep medications ☐ antibiotics ☐ insulin ☐ pain killers ☐ tranquilizers ☐chemotherapy ☐ antidepressants ☐ anticonvulsant ☐ aspirin ☐ Other:
		16. Have you had any previous surgeries?
		17. Do you have any contact allergies or skin sensitivities?
		18. Are you applying liniments or rubs to your skin for any of the following reasons? ☐ Shingles ☐ Eczema ☐ Psoriasis ☐ Pain Relief ☐ Itchiness ☐ Other:

Signature: _____ **Signature:** _____

(Claimant) (Therapist)