SYNERGY
PHYSICAL THERAPY AND PILATES
2919 Welborn St. Suite 100, Dallas, TX 75219
Phone: 214-579-9781 Fax: 214-579-9673

General Health Questionnaire

Name: _____ Date: _____
Birthdate: _____ Age: _____ Gender: M F
Referring Physician: _____

PCP Physician: _____

Primary reason for seeking our services today: _____
_____
If an injury, date of injury, mechanism of injury , if not sure, how long has problem persisted:
_____
_____

Do you currently experience any of these symptoms? Please circle if yes.

Fevers / chills / sweats Unexplained weight loss / gain Unusual fatigue Nausea / vomiting
Headaches Dizziness / lightheadedness / loss of consciousness Blurred vision
Numbness / tingling Weakness Chest pain / palpitations Difficulty breathing / shortness of breath
Difficulty swallowing Changes in bowel/bladder function (starting, stopping)
Recent falls
If you answered yes to any of the above, please explain in detail: _____
_____
_____

Surgical History (Location and Date):
_____
_____

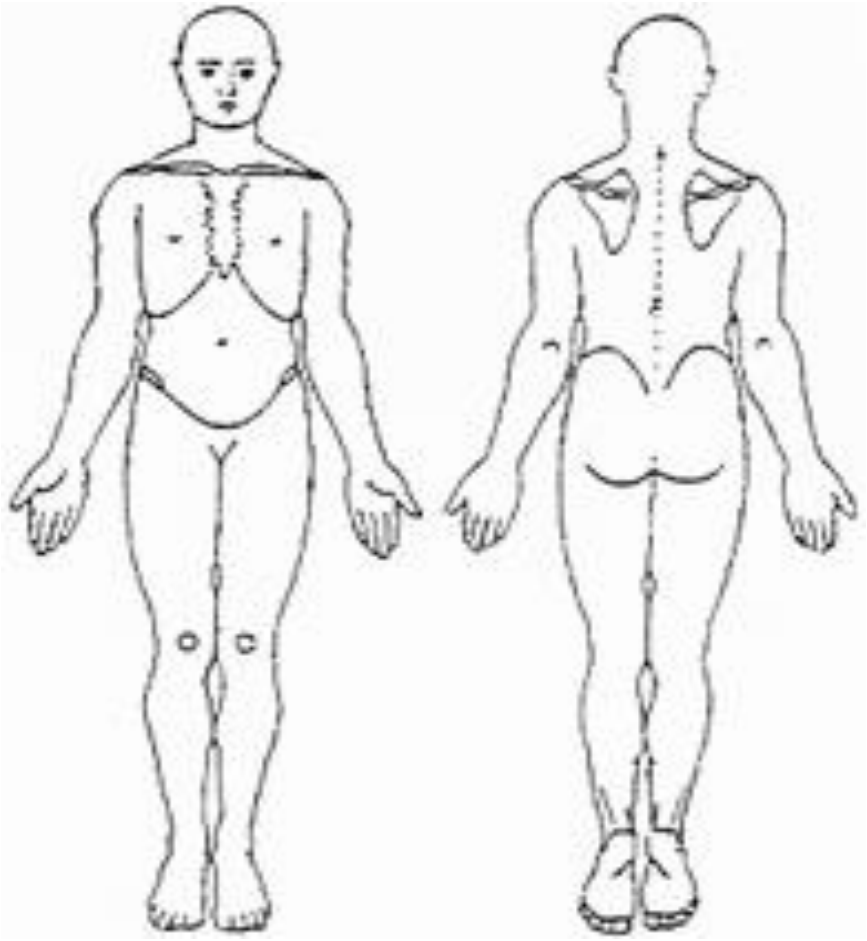
Current medications:
_____

Family medical history of medical problems(birth parents and siblings):
_____
_____

Do you feel safe at home: Yes or No If no, Please explain_____
Are you depressed: Yes or No If yes, Is this something you would like addressed? Yes or No

SYNERGY
PHYSICAL THERAPY AND PILATES
2919 Welborn St. Suite 100, Dallas, TX 75219
Phone: 214-579-9781 Fax: 214-579-9673

Pain Description
Describe your pain
(ex. Burning, aching, dull,
deep, throbbing, sharp): _____



Location: Circle or Mark on Body

Pain Scale: (0 is no pain, 10 is worst imaginable)

Current Pain: 10 6 7 8 9 10

Lowest Pain: 10 6 7 8 9 10

Highest Pain: 10 6 7 8 9 10

Is there anything else you would like to disclose about your health status or previous health problems:_____
_____

What are your goals you hope to achieve from receiving our services: _____
_____

By signing this form you confirm that the above information is correct and accurate to the best of your ability.

_____ _____
Signature of Patient/Guardian Date