POW PHYSICAL THERAPY
Pilates, **O**rthopedics, **W**omen's Health

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Patient Name:_____

Patient Health Questionnaire and History

1. Have you ever had? (If yes, please explain)

High blood pressure	Y/ N_____
Heart or Circulation Disorders	Y/ N_____
Seizures	Y/ N_____
Dizzy Spells	Y/ N_____
Diabetes	Y/ N_____
Cancer	Y/ N_____
Arthritis	Y/ N_____
Immune Deficiency Disease	Y/N_____
Leakage of bladder or bowel	Y/ N_____
Frequent Urination	Y/ N_____
Painful Intercourse	Y/ N_____
Depression	Y/ N_____
Headaches	Y/ N_____
Other	Y/ N_____

2. Please list any surgeries you have had along with procedure and dates, if possible.

   _____

3. Do you have any METAL anywhere in your body (pins/ plates/ pacemaker) other than teeth?

   Y/ N Describe:_____

4. For women only: Are you now pregnant? Y/ N If yes, how many weeks pregnant?_____

   Are you post menopausal? Y/ N If yes, date of last period?_____

5. Do you have any abnormal trouble with vision? Y/ N Hearing? Y/ N

6. List all allergies you may have:_____

7. Have you ever taken steroids or anti coagulants for an extended period of time? Y/ N

8. Have you had any unusual weight gain or loss? Y/ N

9. List all medications you are now taking:_____

   _____