HEALTHY CORE
WELLNESS & REHAB, LTD.

Medical History and Health Screening Form - Female

Directions: Please print this form and fill out the information as completely as possible. Please have the completed form available for your therapist to review with you at your appointment. The information you provide is strictly confidential and will be used to help us provide the most appropriate treatment for you. With your permission, this information may also be shared with your health care provider of choice (such as physician or nurse practitioner). Thank you for your cooperation.

Personal Information

Name:	**Age:**	**Date of Birth:**
Signature:	**Today's Date:**	

Medical History

1. When was your most recent physical/medical check-up?	
2. When was your most recent Pap test?	
3. Date of most recent menstrual cycle (if applicable).	
4. Do you exercise regularly? If yes, what type of activity and how often?____________________________________	☐ Yes ☐ No
5. Do you smoke tobacco? If yes, how often? ______ cigarettes/day ______ packs/day for ______ years	☐ Yes ☐ No
6. If you used to smoke, when did you quit?	

7. Please check the medical conditions below if they apply to you:

☐ Diabetes
☐ Chest pain/Angina
☐ Heart disease
☐ High blood pressure
☐ Pacemaker
☐ Asthma
☐ Lung disease
☐ Tuberculosis
☐ Respiratory infection
☐ Stroke
☐ Vascular disease
☐ Headaches
☐ Migraines
☐ Seizure disorder
☐ Osteoarthritis
☐ Rheumatoid arthritis
☐ Osteoporosis/Osteopenia
☐ Hepatitis
☐ Kidney disease
☐ Anemia
☐ Irritable bowel syndrome
☐ Urinary tract infections
☐ Kidney stones
☐ Cancer
☐ Neuropathy
☐ Thyroid disease
☐ Ulcers
☐ Pelvic organ prolapse
☐ Yeast infection
☐ Sexually transmitted disease (STD)
☐Other:____

Notes/Explanation for any item checked above:

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8. Please list any abdominal/pelvic surgeries you have previously had, including approximate dates:
9. Please list any other surgeries you have previously had, including approximate dates:
10. Please list any relevant diagnostic tests, including approximate dates:
11. Current prescription or over-the-counter medications and dosages:

Pregnancy History

12. Number of full-term pregnancies	
13. Number of vaginal deliveries ___________ Number of C-sections________________	
14. Did you have an episiotomy with any of your deliveries? If yes, were there any problems with healing? ☐ Yes ☐ No	☐ Yes ☐ No
15. Describe any other delivery complications:	
16. Are you currently pregnant? ☐ Yes ☐ No Are you actively trying to get pregnant? ☐ Yes ☐ No	

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Reason for Physical Therapy

17. Primary reason for seeking physical therapy:
18. **Your** goals for physical therapy:

Pain Assessment

19.	If you currently have pain, please rate your current pain from 1-10 (10 being the worst).	
20.	Where is your pain located?	
21.	How long have you had this condition?	
22.	Is your condition: ☐ Improving ☐ Getting worse ☐ No different ☐ Variable	
23.	Do you have any limitations because of your pain? If yes, please explain:____	☐ Yes ☐ No

Thank you for your time in completing this information.