HEALTH QUESTIONNAIRE – PART II

Name		Date	SS #
Age	Height	Weight	Dominant Hand ☐ R ☐ L
Do you have a Pacemaker? ☐ Yes ☐ No		Are you Pregnant? ☐ Yes ☐ No	
Employer		Occupation	
Employer Address		Work Status ☐ Full Duty ☐ Light Duty ☐ Not working	
Medications (please list below or attach list)		Allergies	

Do you have any other medical conditions?

☐ Yes ☐ No If yes, please describe?

Have you had any other surgeries?

☐ Yes ☐ No If yes, please describe?

Do you currently smoke? ☐ Yes ☐ No	Have you fallen in the past year? ☐ No ☐ Yes, _____ times

PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing this form, I acknowledge that I have been shown the Dullmeyer Physical Therapy, LLC dba ProForm^{PT} "Notices of Privacy Practices" and have been provided an opportunity to review it. I also acknowledge that if I desire a copy of this notice, one can be obtained at my request.

Name _____ Birth date _____

Signature _____ Date _____