Jennifer M. Hays, M.P.T.

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Physical Therapy & Wellness of Richmond

WELLNESS CONSULTATION

Name: _____ Date: _____

What do you hope to gain from this consultation?

1. _____
2. _____

MEDICAL HISTORY

Please list ALL prescription and non-prescription medications, including vitamins and supplements.

_____

_____

Please list ALL surgeries.

_____

_____

Please list ALL allergies.

_____

_____

Have you had or do you currently have any of the following conditions:

Asthma	_____YES	_____NO	Scoliosis	_____YES	_____NO
Bronchitis	_____YES	_____NO	Bowel/Bladder Problems	_____YES	_____NO
COPD	_____YES	_____NO	Chest Pain	_____YES	_____NO
Emphysema	_____YES	_____NO	Pregnancy	_____YES	_____NO
High Blood Pressure	_____YES	_____NO	Depression	_____YES	_____NO
High Cholesterol	_____YES	_____NO	Dizziness/Fainting	_____YES	_____NO
Heart Attack	_____YES	_____NO	Tinnitus (ringing in ears)	_____YES	_____NO
Stroke/TIA	_____YES	_____NO	Tobacco Use	_____YES	_____NO
Diabetes	_____YES	_____NO	Cancer	_____YES	_____NO
Thyroid Disease	_____YES	_____NO	Arthritis	_____YES	_____NO
Osteoporosis	_____YES	_____NO	Fibromyalgia	_____YES	_____NO

Other _____

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LIFESTYLE

What is your general activity level? _____Inactive _____Moderately Active _____Very Active
What is your general stress level? _____Mild _____Moderate _____Severe

Work/Volunteer History: Type_____

Hobbies: Type_____

Exercise: Type_____
Frequency_____

Sleep Habits: Approximate # hours/night_____

Diet: Describe_____

Smoker: _____YES _____NO _____#/day, week
Alcohol Consumption: _____YES _____NO _____#/day, week
Caffeine Consumption: _____YES _____NO _____#/day, week

CURRENT CONDITION/LIMITATION (IF APPLICABLE)

Describe: _____
Onset Date: _____

In the past, have you been treated for this condition? _____YES _____NO
If yes, by whom? _____
Currently, are you being treated for this condition? _____YES _____NO
If yes, by whom? _____

Please list the following:
Primary Care Physician_____
Specialty Physician(s)_____
Other (include massage therapist, chiropractor, etc.)_____
_____