



Medical History Questionnaire

Name: _____ Daytime Phone: _____

Referring Physician: _____ Primary Care Physician: _____

Emergency Contact: _____ Phone: _____

Occupation: _____ Currently working? Yes No If no, is this due to this injury? _____ If not working, what was the last date worked? _____

Onset date of this injury/illness? _____ Have you had surgery for this injury/illness? _____

Type of surgery/dates: _____

Are you currently taking any prescription or non-prescription medications? Yes No

Please list or attach copy of meds: _____

What diagnostic tests have you had for these symptoms? (Please list dates)

X-Rays _____ MRI _____ CT _____ Myelogram _____ EMG _____

Describe how these symptoms affect your ability to function compared to before onset? _____

In order to better identify how we can best help you, what are your expectations or goals from Physical Therapy? _____

MEDICAL HISTORY:

Do you now have or have you ever had:

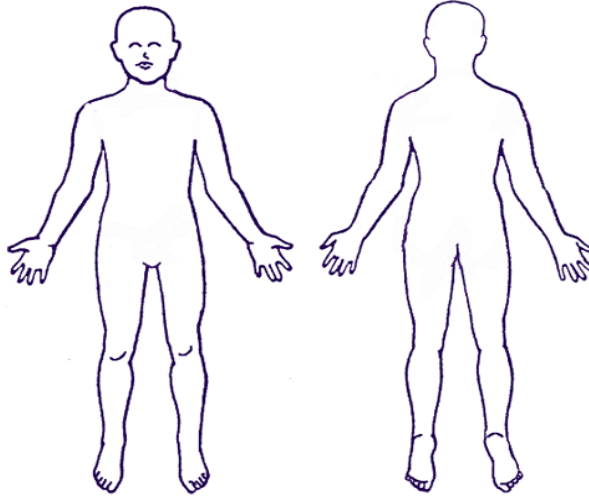
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|--|----------------|---|----------------|
| Chest pain/Angina | ___ Yes ___ No | Anemia | ___ Yes ___ No |
| Abnormal EKG | ___ Yes ___ No | Multiple Sclerosis | ___ Yes ___ No |
| Heart palpitations | ___ Yes ___ No | Swollen, stiff or painful joints | ___ Yes ___ No |
| Shortness of breath | ___ Yes ___ No | Fibromyalgia | ___ Yes ___ No |
| High blood pressure | ___ Yes ___ No | Osteoporosis | ___ Yes ___ No |
| Dizziness, faintness, or loss of consciousness | ___ Yes ___ No | Arthritis | ___ Yes ___ No |
| Heart Attack/Heart Surg. | ___ Yes ___ No | Numbness or Tingling | ___ Yes ___ No |
| Have a Pacemaker | ___ Yes ___ No | Back injury | ___ Yes ___ No |
| Other heart trouble | ___ Yes ___ No | Bowel/Bladder problems | ___ Yes ___ No |
| Stroke/TIA | ___ Yes ___ No | Headaches | ___ Yes ___ No |
| Cough on exertion | ___ Yes ___ No | Sleeping Problems | ___ Yes ___ No |
| Breathlessness at rest | ___ Yes ___ No | Emotional Problems | ___ Yes ___ No |
| Asthma/Bronchitis | ___ Yes ___ No | Depression | ___ Yes ___ No |
| Lung disease | ___ Yes ___ No | Infectious Diseases | ___ Yes ___ No |
| Allergies | ___ Yes ___ No | Joint Replacements | ___ Yes ___ No |
| Hypoglycemia | ___ Yes ___ No | Vision/Hearing Problems | ___ Yes ___ No |
| Diabetes | ___ Yes ___ No | Any pins or metal implants | ___ Yes ___ No |
| Gout | ___ Yes ___ No | Surgeries | ___ Yes ___ No |
| Cancer/Chemo/Radiation | ___ Yes ___ No | Injuries/surgeries of neck, Back/shoulder/elbow, Hand/knee/leg/ankle/foot | ___ Yes ___ No |
| Weight loss | ___ Yes ___ No | Are you allergic to latex? | ___ Yes ___ No |
| Ulcers/Stomach problems | ___ Yes ___ No | Are you pregnant? | ___ Yes ___ No |
| Hepatitis/Jaundice | ___ Yes ___ No | Do you smoke? | ___ Yes ___ No |
| Kidney problems, stones | ___ Yes ___ No | | |
| Seizures | ___ Yes ___ No | | |

Please explain any of above "Yes" answers or describe any medical problems that would limit your ability to participate in a physical program? _____



PATIENT SELF REPORT

Where are your symptoms located? Please mark areas of symptoms on body below:



Please rate your pain by circling number on scale

0 1 2 3 4 5 6 7 8 9 10
(No pain) (Excruciating pain)

How/when did your symptoms begin? _____

How would you describe your symptoms?

(Please circle) aching/sharp/burning/tingling/stabbing/throbbing/radiating/numbness/weakness
other _____

How much does your pain interfere with your daily activities?

(Please circle) Constantly (76-100%) Frequently (51-74%) Occasionally (26-50%) Intermittently (0-25%)

What makes your symptoms worse? sitting/standing/bending/lifting/other _____

What makes your symptoms better? _____

Please list any interventions prior to physical therapy (injections, splints, medications, etc.)

Who have you seen for these symptoms? Primary Care Doctor/Orthopedist/Neurologist
Physical Therapist/Chiropractor/Massage Therapist/Other Specialist _____
