Medical History Questionnaire

The purpose of this questionnaire is to help the physical therapist understand your health status. Please complete this form and the therapist will answer any questions you may have during your exam. This form is considered part of your medical records.

Name:_____ DOB:_____
Emergency Contact Name:_____ Phone:_____
Date of next appointment with Referring Physician:_____
Last date worked due to this injury:_____ Date returned to work:_____
Have you had surgery for this injury? YES NO Type of Surgery / Date:_____
Is an attorney involved in this case? YES NO Attorney's name:_____
List of current non-prescription and prescription medications:_____
_____

Have you had any of the following Medical or Rehabilitative care for this injury / episode?

	YES	NO		YES	NO
Chiropractor	___	___	CT Scan	___	___
General Practitioner	___	___	MRI	___	___
Occupational Therapy	___	___	X-Ray	___	___
Physical Therapy	___	___	EMG/NCV	___	___
Massage Therapy	___	___	Emergency Room	___	___
Neurologist	___	___	Podiatrist	___	___
Orthopedist	___	___	Myelogram	___	___

Do you now, or have you ever had any of the following?

	YES	NO		YES	NO
Asthma, Bronchitis or Emphysema	___	___	Headaches or migraines	___	___
Shortness of breath / chest pain	___	___	Vision or hearing difficulty	___	___
Coronary heart disease or angina	___	___	Numbness and / or tingling	___	___
Do you have a pacemaker?	___	___	Dizziness or fainting	___	___
Heart attack / Heart surgery	___	___	Weakness	___	___
High blood pressure	___	___	Weight loss / energy loss	___	___
High cholesterol	___	___	Hernia	___	___
Blood clot / emboli / DVT	___	___	Epilepsy / seizures	___	___
Stroke / TIA	___	___	Thyroid issue	___	___
Allergies (seasonal / meds / food)	___	___	Incontinence	___	___
Pins or metal implants	___	___	Bowel or bladder changes	___	___
Joint replacement	___	___	Neck injury / surgery	___	___
Diabetes	___	___	Shoulder injury / surgery	___	___
Infectious disease (MRSA, HIV, etc)	___	___	Elbow / hand injury / surgery	___	___
Cancer / Chemotherapy / XRT	___	___	Back injury / surgery	___	___
Arthritis / swollen joints	___	___	Knee injury / surgery	___	___
Osteoporosis	___	___	Ankle / foot injury / surgery	___	___

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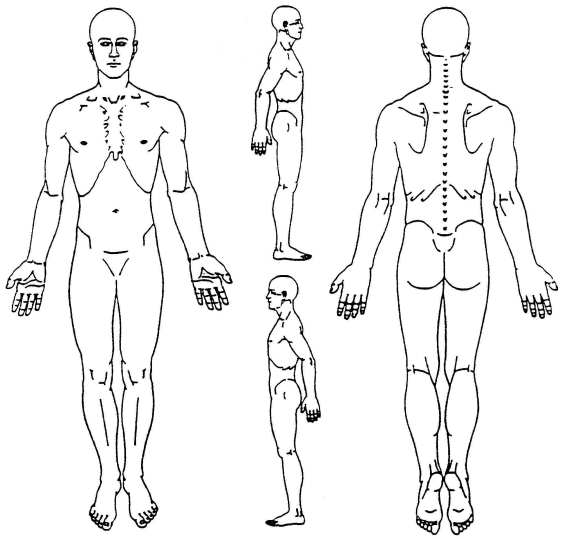
	YES	NO		YES	NO
Sleeping problems / difficulty	___	___	Multiple sclerosis/Parkinsons	___	___
Smoke cigarettes	___	___	Depression	___	___
Latex sensitivity/ allergy	___	___			

FOR WOMEN ONLY:

	YES	NO		YES	NO
Pelvic inflammatory Disease	___	___	Endometriosis	___	___
Irregular menstrual cycle	___	___	Incontinence (urinary/fecal)	___	___
Complicated pregnancy/delivery	___	___	Are you pregnant?	___	___

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Be very precise when drawing the location of your pain. Use the key to indicate the type of symptoms.

Key: Pins & Needles = OOO Stabbing = /// Burning = XXX Deep Ache = ZZZ



Please rate your current level of pain on the following scale (circle one): 0 1 2 3 4 5 6 7 8 9 10

Please rate your worst level of pain in the last 24 hours: (circle one): 0 1 2 3 4 5 6 7 8 9 10

Please rate your best level of pain in the last 24 hours: (circle one): 0 1 2 3 4 5 6 7 8 9 10

Patient / Guardian Signature:_____ Date:_____

Physical Therapist initials:_____ Date:_____