MARYLAND PHYSICAL THERAPY

Patient Questionnaire/Medical History Form

Under Medicare and the State practice acts, Maryland Physical Therapy is required to obtain a complete medical history on all patients examined and treated. This information is protected under the Health Insurance Portability and Accountability Act (HIPPA). Please answer all of the following questions to the best of your ability.

Last Name: _____ First Name: _____ MI: _____

DOB: _____/_____/_____ Age: _____ How Do You Identify: Male / Female

Height: _____ Weight: _____ Hand Dominance: R / L

Occupation: _____ Is this referral work related? Y / N

Emergency Contact: _____ Relation: _____

Emergency Contact's Phone Number: _____

Referring Healthcare Provider: _____

Primary Care Physician (PCP): _____

If this referral is due to an accident, please circle the location where the accident occurred:
Home Automobile Work Sporting Activity Other

Are you following specific lifting restrictions? Y / N

Do you live alone? Y / N Do you have stairs inside or outside of your home? Y / N

Please circle Y or N to the following conditions:

Hypertension	Y / N	Osteoarthritis	Y / N
High Cholesterol	Y / N	Rheumatoid Arthritis	Y / N
Bowel/Bladder Dysfunction	Y / N	Osteoporosis or Osteopenia	Y / N
Acid Reflux or Ulcers	Y / N	Scoliosis	Y / N
Thyroid Disorder	Y / N	Headaches or Migraines	Y / N
Bleeding Disorder	Y / N	Dizziness or Fainting	Y / N
Seizures/Epilepsy	Y / N	Cancer (location:	Y / N
Lyme disease	Y / N	Recent Infections	Y / N

Pregnant	Y / N	Multiple Sclerosis	Y / N
Fibromyalgia	Y / N	Congestive Heart Failure	Y / N
Lupus	Y / N	Depression	Y / N
Diabetes	Y / N	Heart Attack	Y / N
Cardiac Bypass	Y / N	Cardiac Stents	Y / N
Angina/Chest Pain	Y / N	Hepatitis	Y / N
Emphysema	Y / N	COPD	Y / N
Asthma	Y / N	Kidney Disease	Y / N

Do you have/wear (please circle):

Glasses Contacts Dentures Cardiac Pacemaker Metal Implant Hearing Aides

Please list your allergies: _____.

Please list your current medications/supplements, including dosage and frequency: _____
_____
_____
_____.

Please list previous surgeries, including dates: _____
_____
_____
_____.

How would you describe your current health (please circle):

Excellent Very Good Good Fair Poor

Do you use any of the following (please circle):

Cane Walker Crutches Wheelchair

Have you fallen two or more times within the past 12 months? Y / N

What is the reason for your visit today? _____.

Have you experienced similar symptoms/deficits in the past? Y / N

What are the goals you would like to achieve at the completion of Physical Therapy? _____
_____.

Have you participated in Physical Therapy elsewhere prior to today's appointment? Y / N

Has any diagnostic testing been performed recently (please circle all that apply):
X-Ray Bone Density Scan Ultrasound MRI EMG CT Scan
Blood Work

Please circle the following face that symbolizes the pain you are currently experiencing:
😁 🙂 😐 😕 😭

How would you describe the pain you are experiencing (please circle):
Sharp Dull Achy Burning. Stiff Deep Pins and Needles

Is your symptoms (please circle):
Become Worse The Same Improving

What activities or positions increase your symptoms: _____
_____
_____.

What activities or positions decrease your symptoms: _____
_____
_____.

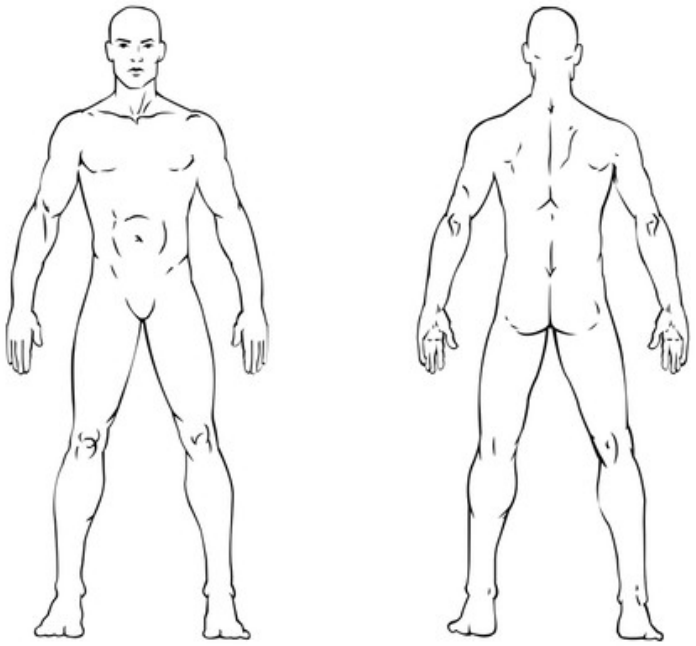
Is your symptoms (please circle):
Constant Intermittent

Have you experienced loss of sensations?
Y / N

Do you feel weak? Y / N

Have you experienced any swelling? Y / N

Please circle the location of your symptoms:



To the best of my knowledge, I have given and included all pertinent information,

Patient/Guardian Signature: _____ Date: _____

Medical history reviewed by Physical Therapist and used in establishing this patient's plan of care.

Physical Therapist's Signature: _____ Date: _____