# KAH Premium Physical Therapy

## Medical History Questionnaire

Name:_____ Date of last health check-up: __/__/__

Have you had surgery for this injury? **Yes / No** Emergency Contact Name/Relation:_____

Surgery Date:__/__/__ Emergency Contact Phone:_____

Occupation:_____ **FT / PT**

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

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Asthma, Bronchitis, or Emphysema | ___ | ___ | Severe or Frequent Headache | ___ | ___ |
| Shortness of Breath / Chest Pain | ___ | ___ | Vision or Hearing Difficulty | ___ | ___ |
| Coronary Heart Disease or Angina | ___ | ___ | Numbness or Tingling | ___ | ___ |
| Do you have a pacemaker? | ___ | ___ | Dizziness or Fainting | ___ | ___ |
| High Blood Pressure | ___ | ___ | Weakness | ___ | ___ |
| Heart Attack / Heart Surgery | ___ | ___ | Weight Loss / Energy Loss | ___ | ___ |
| Blood Clot / Emboli | ___ | ___ | Epilepsy / Seizures | ___ | ___ |
| Stroke / TIA | ___ | ___ | Neck Injury / Surgery | ___ | ___ |
| Allergies | ___ | ___ | Shoulder Injury / Surgery | ___ | ___ |
| Pins or Metal Implants | ___ | ___ | Elbow / Hand Injury / Surgery | ___ | ___ |
| Cancer | ___ | ___ | Back Injury / Surgery | ___ | ___ |
| Osteoporosis | ___ | ___ | Knee Injury /Surgery | ___ | ___ |
| Sleeping Problems / Difficulty | ___ | ___ | Leg / Ankle Injury/Surgery | ___ | ___ |
| Latex Sensitivity / Allergy | ___ | ___ | Arthritis | ___ | ___ |
| Infectious Disease | ___ | ___ | Joint Replacement | ___ | ___ |

Please provide more detail if you have answered yes to any of the above:_____

_____

***. Describe your symptoms*** _____

_____

*a. When did your symptoms start?* _____

*b. How did your symptoms begin?* _____

***How often do you experience your symptoms?***

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

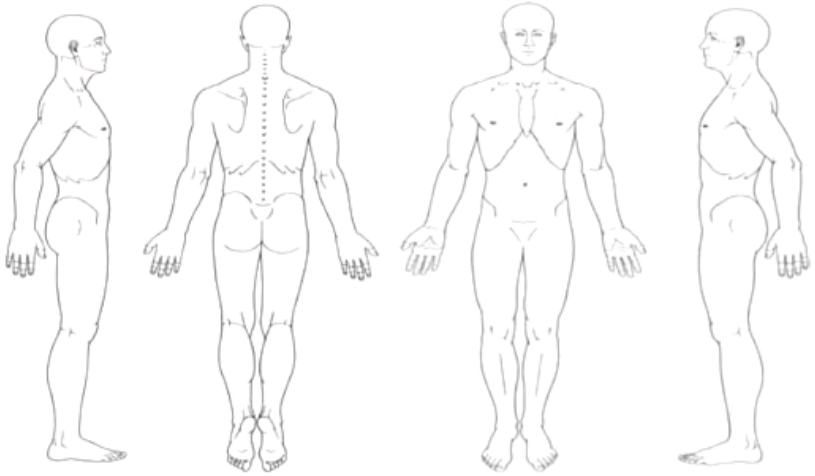
***What describes the nature of your symptoms?***

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

***How are your symptoms changing?***

① Getting Better
② Not Changing
③ Getting Worse

***Indicate where you have pain or other symptoms***



***Turn Over*** →

***In general would you say your overall health right now is...***

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

***Who have you seen for your symptoms?***

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

*a. What treatment did you receive and when?* _____

*b. What tests have you had for your symptoms and when were they performed?*

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

***Have you had similar symptoms in the past?***

① Yes ② No

*a. If you have received treatment in the past for the same or similar symptoms, who did you see?*

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

***During the past 4 weeks how much of the time has your condition interfered with your social activities?***
*(like visiting with friends, relatives, etc)*

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

***During the past 4 weeks:***

*a.* ***Referring to the pain scale below*** *please indicate the intensity of your symptoms, on a scale of 1-10 for each of the following:*

*At Worst:* (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

*At Best:* (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

*Currently:* (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

*b. How much has pain interfered with your normal work (including both work outside the home, and housework)*

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

| | | |
|---|---|---|
| **0** | **Pain Free** | **No medication needed** |
| **1** | **Very minor annoyance-occasional minor twinges** | **No medication needed** |
| **2** | **Minor annoyance-occasional strong twinges** | **No medication needed** |
| **3** | **Annoying enough to be distracting** | **Mild painkillers (aspirin,ibuprofen) are effective** |
| **4** | **Can be ignored if you are really involved in your work, but still distracting** | **Mild painkillers relieve pain for 3 to 4 hours** |
| **5** | **Can not be ignored for more than 30 minutes** | **Mild painkillers relieve pain for 3 to 4 hours** |
| **6** | **Can not be ignored for any length of time, but you can still go to work and participate in social activities** | **Strong painkillers (Codeine, Tramadol) reduce pain for 3 to 4 hours** |
| **7** | **Makes it difficult to concentrate, interferes with sleep. You can still function with effort** | **Stronger painkillers are only partially effective. Requires strongest (Oxycontin/Morphine) for relief.** |
| **8** | **Physical activity severely limited. You can read and converse with effort. Nausea and dizziness may occur as factors of pain** | **Stronger painkillers are minimally effective. Strongest painkillers reduce pain 3 to 4 hours** |
| **9** | **Unable to speak, Crying out or moaning uncontrollably- near delirium** | **Strongest painkillers are only partially effective.** |
| **10** | **Unconscious. Pain makes you pass out.** | **Strongest painkillers are only partially effective.** |

Patient Signature: _____ Date:_____