

Medical Questionnaire – Physical Therapy

Patient Name _____ Date _____ Date of Birth _____ Age _____

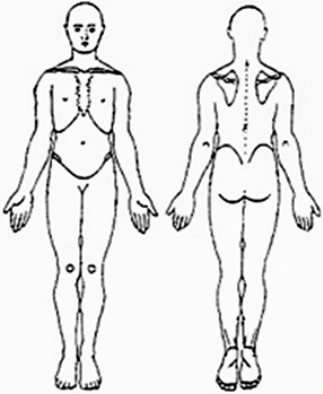
Occupation _____ Employer _____ Hrs/Wk _____

What problem or diagnosis brings you here today? _____

Side of Injury R L Date of Injury? _____ Who referred you to PT? _____

Briefly describe your symptoms: _____

Describe how your condition or injury occurred: _____



Shade your areas of pain or discomfort on the figures to the left:

Please rate your pain on the scale below from 0 to 10:

(0 = no pain; 10 = worst pain imaginable/emergency room pain)

Pain at rest: 0 1 2 3 4 5 6 7 8 9 10

Pain with activity: 0 1 2 3 4 5 6 7 8 9 10

What is the frequency of your pain? Constant Intermittent

Does your pain wake you at night? Y N

How many times? _____

What eases your symptoms? _____

What aggravates your symptoms? _____

Are your symptoms getting Better Worse Same Is your pain worse in the AM PM Mid-Day?

Are you currently working? Y N Are you currently on Light duty Normal Duty Is this a Motor Vehicle claim? Y N

What activities at home, work or recreational are you unable to perform? _____

Have you had a similar condition before? Y N If yes, when _____

Have you had tests for this condition? Y N If yes, results: _____

Check tests: X-Rays MRI Bone Scan CT Scan Nerve Tests Blood Tests Other _____

Have you had any other treatment for this condition? Y N If yes, what kind? PT OT Chiropractic Massage

Current Level of Physical Activity High Medium Low List: _____

What goals do you hope to accomplish with Physical Therapy? _____

Medical History (Check any that apply)

- | | | | | |
|--|---|--|---|--------------------------------|
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> MRSA | <input type="checkbox"/> Other |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker/Nitroglycerin | |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Poor Circulation/Raynaud's | |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Polio | |
| <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Bowel or Bladder Problems | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Menopause | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Carpel Tunnel Syndrome | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> TB | |
| <input type="checkbox"/> Chest/Abdominal Surgery | <input type="checkbox"/> Fractures | <input type="checkbox"/> Major Spinal Injury | <input type="checkbox"/> Traumatic Injury/MVA | |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Frequent Falls | | | |

Are you pregnant?
 Y N

Do you have a history of whiplash or low back pain? Y N If so when/how long? _____

Do you smoke tobacco? Y N If yes, how much? _____ how long? _____

Medications/Allergies/Surgeries

List current medications: _____

List current allergies: _____

List all surgeries: _____

Signature _____ Date _____