Medical History Questionnaire

The purpose of this questionnaire is to help us understand your health status. Please complete this form and your therapist will answer any questions during your exam. This form is considered part of your medical record.

Patient Name: ____ Date of Birth:_______________

Referring Provider: ____

Primary Care Physician:____

What brings you in for physical therapy? ____

____

Have you had surgery for this ailment? Yes No
Type(s) and Date(s) of Surgery:____

Pain (draw a vertical line where you would rate your pain intensity):

At Rest 0------------------------------------5------------------------------------10
At Worst 0------------------------------------5------------------------------------10
At Best 0------------------------------------5------------------------------------10
No Pain Maximum Pain tolerable

My pain can be described as: (please circle all that apply)
Constant Intermittent Sharp Dull Aching Stabbing Numbness Pins/Needles

What makes your pain better? ____

What makes your pain worse? ____

Have you had any of the following care for **THIS** injury/episode? (please circle all that apply)
Chiropractor General Practitioner Occupational therapy Physical therapy
Massage therapy Neurologist Orthopedist CT Scan EMG/NCV MRI
Myelogram X-rays Emergency Room Care Podiatrist

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

If you have a medication list please give a copy to the front desk. Thank you.

Please list all prescription and non-prescription medications, vitamins, or herbal medications
Name: ________________ Dose: ________ Frequency: ________ Reason: _________________
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Name: ________________ Dose: ________ Frequency: ________ Reason: _________________

Date of Last General Health Check-Up: _________________
Height: ____________________ Weight: __________________

Surgical/Trauma History: Please list type of surgery/trauma, and month/year it occurred:
____
____

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

	Yes	No
Allergies	____	____
Anemia	____	____
Anxiety	____	____
Arthritis/Swollen Joints	____	____
Asthma	____	____
Auto Immune Disorder	____	____
Cancer/Chemotherapy/Radiation	____	____
Cardiac Conditions	____	____
Cardiac Pacemaker	____	____
Chemical Dependency	____	____
Circulation Problems	____	____
Depression	____	____
Diabetes	____	____
Dizzy Spells/Fainting	____	____
Emphysema/Bronchitis	____	____
Fibromyalgia	____	____
Fractures	____	____
Gallbladder Problems	____	____
Frequent Headaches	____	____
Hearing Impairment	____	____
Hepatitis	____	____
High Cholesterol	____	____
High/Low Blood Pressure	____	____
HIV/AIDS	____	____
Incontinence/Bowel Problems	____	____
Kidney Problems	____	____
Metal Implants	____	____
MRSA	____	____
Multiple Sclerosis	____	____
Muscular Disease	____	____
Osteoporosis	____	____
Parkinson's	____	____
Rheumatoid Arthritis	____	____
Seizures/Epilepsy	____	____
Do You Smoke?	____	____

	Yes	No
Speech Problems	____	____
Strokes/TIA	____	____
Thyroid Disease/Goiter	____	____
Tuberculosis	____	____
Vision Problems	____	____
Hernia	____	____
Infectious Disease	____	____
Gout	____	____
Reiter's Syndrome	____	____
Sleeping Difficulty	____	____
Numbness or Tingling	____	____
Weakness	____	____
Weight Gain/Loss	____	____
Energy Loss	____	____
Ehlers-Danlos Syndrome	____	____
Chronic Fatigue Syndrome	____	____
Neck Injury	____	____
Back Injury	____	____
Shoulder Injury	____	____
Elbow Injury	____	____
Wrist/Hand Injury	____	____
Leg Injury	____	____
Knee Injury	____	____
Ankle/Foot Injury	____	____
Latex/Tape Sensitivity	____	____

FOR WOMEN ONLY:

	Yes	No
Pelvic Inflammatory Disease	____	____
Irregular Menstrual Cycle	____	____
Endometriosis	____	____
Complicated Pregnancies	____	____
Complicated Deliveries	____	____
C-Section Deliveries	____	____
Vaginal Deliveries	____	____
Are you pregnant?	____	____

Have you had an injury as a result of a fall in the past year? Yes No
Have you had two or more falls in the last year? Yes No

Please list any other conditions you have, or have ever had that are not listed above that you feel could be important to your care: ____

____

____

Patient Goals: What do you expect to get from treatment? ______________________________

____

____

____

Patient/Guardian Signature: ____________________________________ Date: ______________