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 Naturopath Acupuncture

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: _____
Name: _____ Dose: _____ Frequency: _____ Reason: _____
Name: _____ Dose: _____ Frequency: _____ Reason: _____
Name: _____ Dose: _____ Frequency: _____ Reason: _____
List additional medications on a separate sheet.

Date of Last General Health Check-Up: _____
Height: _____ Weight: _____

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

Do you now have, or have you ever had, any of the following? (C=current, P=past)

	C	P		C	P
Allergies	___	___	Strokes/TIA	___	___
Anemia	___	___	Thyroid Disease/Goiter	___	___
Anxiety	___	___	Tuberculosis	___	___
Arthritis/Swollen Joints	___	___	Vision Problems	___	___
Asthma	___	___	Hernia	___	___
Auto Immune Disorder	___	___	Infectious Disease	___	___
Cancer/Chemotherapy/Radiation	___	___	Gout	___	___
Cardiac Conditions	___	___	Reiter's Syndrome	___	___
Cardiac Pacemaker	___	___	Sleeping Difficulty	___	___
Chemical Dependency	___	___	Numbness or Tingling	___	___
Circulation Problems	___	___	Weakness	___	___
Depression	___	___	Weight Gain/Loss	___	___
Diabetes	___	___	Energy Loss	___	___
Dizzy Spells/Fainting	___	___	Ehlers-Danlos Syndrome	___	___
Emphysema/Bronchitis	___	___	Chronic Fatigue Syndrome	___	___
Fibromyalgia	___	___	Head/Neck Injury	___	___
Fractures	___	___	Back Injury	___	___
Gallbladder Problems	___	___	Shoulder Injury	___	___
Frequent Headaches	___	___	Elbow Injury	___	___
Hearing Impairment	___	___	Wrist/Hand Injury	___	___
Hepatitis	___	___	Hip/Leg Injury	___	___
High Cholesterol	___	___	Knee Injury	___	___
High/Low Blood Pressure	___	___	Ankle/Foot Injury	___	___
HIV/AIDS	___	___	Recreational Drug Use	___	___
Incontinence/Bowel Problems	___	___	Mental Health Treatment	___	___
Kidney Problems	___	___	**Latex/Tape Sensitivity**	Yes	No
Metal Implants	___	___			
MRSA	___	___	<u>FOR WOMEN ONLY:</u>		
Multiple Sclerosis	___	___	Pelvic Inflammatory Disease	___	___
Muscular Disease	___	___	Irregular Menstrual Cycle	___	___
Osteoporosis	___	___	Endometriosis	___	___
Parkinson's	___	___	Complicated Pregnancies	# _____	
Rheumatoid Arthritis	___	___	Complicated Deliveries	# _____	
Seizures/Epilepsy	___	___	C-Section Deliveries	# _____	
Do You Smoke?	___	___	Vaginal Deliveries	# _____	
Speech Problems	___	___	**Are you pregnant?**	Yes	No

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
Have you, or are you currently receiving physical, occupation, or speech therapy, or chiropractic services at any other office in this calendar 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: _____