

## Medical Questionnaire

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

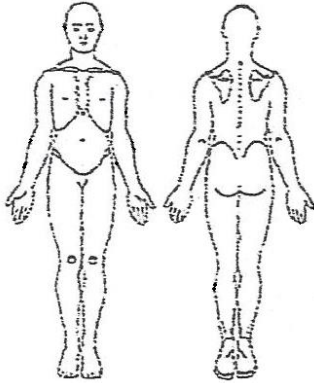
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Hrs/Wk \_\_\_\_\_

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: \_\_\_\_\_

CIRCLE 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

CIRCLE Current Level of Physical Activity:  High  Medium  Low List: \_\_\_\_\_

What goals do you hope to accomplish with Physical Therapy? \_\_\_\_\_

## Medical History (Check all that apply)

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

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 \_\_\_\_\_