

Medical Questionnaire

Patient Name: _____ Date _____ Date of Birth _____ Age _____

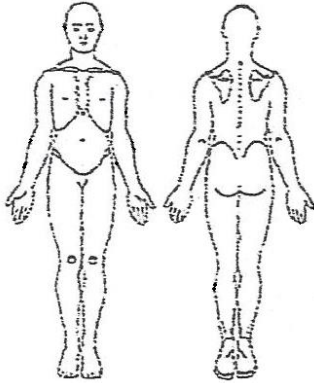
Occupation: _____ Employer: _____ Hrs/Wk _____

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 _____