Patient Questionnaire/Medical History Form

Under Medicare and State practice acts, we are required to obtain a complete medical history on all patients.
The information is protected under HIPAA laws. Please answer the below to the best of your ability.

Last Name: _____ **First Name:** _____ **MI:** _____ Date: ____/____/____

DOB: ____/____/____ Age: _____ Sex: M / F Height: _____ Weight: _____ Hand Dominance: R / L

How did you hear about us? _____

Referring Doctor: _____ Primary Care Doctor: _____

If accident, please indicate where occurred: HOME AUTO WORK SPORTS OTHER Next Doctor's Visit: ____/____/____

Occupation: _____ Current Work Status: _____

Do you have lifting restrictions? Y / N Do you live alone? Y / N Do you have stairs where you live? Y / N

What is the reason for your visit: _____

Briefly describe how/when your problem began: _____

What goals do you expect to achieve with therapy? _____

Date of/onset of injury: ____/____/____ Date of Surgery: ____/____/____ Type of Surgery: _____

Prior treatment for your current chief complaint (circle all that apply) ☐ No treatment received yet

Physical Therapy	Chiropractic Care	Pain Management	Accupuncture
Massage	Personal Training	Athletic Training	Brace/Tape
Surgical Interventions	Injections	Mechanical Traction	Other: _____

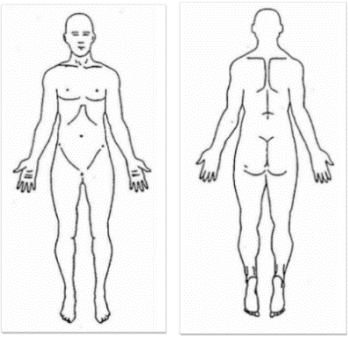
Diagnostic Testing: (circle all that apply)

X-Ray MRI CTScan EMG Doppler Ultrasound Bloodwork Bone Scan Other:_____

Please list body part tested and test date: _____

Have you had similar symptoms in the past: Y / N

Circle where your pain is:



Where did your pain start? _____

Is your pain: ☐ worsening ☐ improving ☐ no change

Describe your pain: ☐ sharp ☐ dull ☐ aching ☐ throbbing

☐ **b**urning ☐ shooting ☐ stabbing ☐ squeezing ☐ constant

What makes it worse? _____

What makes it better? _____

Does pain wake you from sleep? _____

Please rate your pain on 0-10 scale (0 is no pain, 10 is worst imaginable)

Least: 0 1 2 3 4 5 6 7 8 9 10 Worst: 0 1 2 3 4 5 6 7 8 9 10 Present: 0 1 2 3 4 5 6 7 8 9 10

Do you have any tingling/numbness/ loss of sensation: Y / N if so, where? _____

Do you have any weakness? Y / N if so, where? _____ **Do you have any swelling?** Y / N if so, where? _____

Have you fallen two (2) or MORE TIMES within the past 12 months? Y / N

Have you sustained an injury as a result of these falls: Y / N

Do you use any of the following? Cane Walker Crutches Wheelchair

Over the last 2 weeks, how often have you been bothered by any of the following?:

	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things:	0	1	2	3
2. Feeling down, depressed, or hopeless:	0	1	2	3

Please circle Yes or No if you have or had any of the following conditions:

High Blood Pressure	Y / N	Heart Attack	Y / N	Osteoarthritis	Y / N
High Cholesterol	Y / N	Cardiac Stents	Y / N	Rheumatoid Arthritis	Y / N
Diabetes	Y / N	Cardiac Bypass	Y / N	Osteoporosis/Osteopenia	Y / N
Acid Reflux or Ulcers	Y / N	Angina/Chest Pain	Y / N	Scoliosis	Y / N
Thyroid disorder	Y / N	Congestive Heart Failure	Y / N	Headaches/Migraines	Y / N
Bleeding disorder	Y / N	Emphysema	Y / N	Cancer (site_____)	Y / N
Seizures/Epilepsy	Y / N	COPD	Y / N	Recent Infection	Y / N
Lyme Disease	Y / N	Asthma	Y / N	Multiple Sclerosis	Y / N
Fibromyalgia	Y / N	Stroke	Y / N	Depression	Y / N
Lupus	Y / N	Dizziness or Fainting	Y / N	Currently Pregnant	Y / N
Kidney Stones	Y / N	Hepatitis	Y / N	# of weeks _____	

Please circle any you have: Glasses Contacts Dentures Pacemaker Metal Impant Hearing Aides

Please circle any of the following that apply:
Mentral Disorder: (Type)_____ Dementia/Alzheimer HIV/AIDS Parkinson's Hepatitis (Type): _____

Are you a tobacco user? Y / N
List all allergies you may have: _____
List all previous surgeries and dates (within previous 5yrs):

_____

_____

_____

List all medications/supplements you are taking, include dosage and frequency:

_____

_____

_____

Emergency Contact? Name_____ **Relation** _____ **Phone**_____

To the best of my ability, I have provided and included all pertinent medical information

Patient/Guardian signature: _____ Date: ____/____/_____

Medical History reviewd by physical or occupational therapist and utilized in determining the plan of care

Therapist signature: _____ Date: _____/____/_____