

# Medical History Questionnaire

Name: \_\_\_\_\_  
 Family Physician \_\_\_\_\_  
 Have you had surgery due to this injury  Yes  No  
 Type of Surgery \_\_\_\_\_

Referring Physician \_\_\_\_\_  
 Reason you are here today: \_\_\_\_\_  
 Number of Surgeries \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

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

If yes, please list them \_\_\_\_\_

\*\* If you need more space, please continue listing on back of this page.\*\*

Have you had any of the following Medical or Rehabilitative Services for this Injury/Episode?

- | YES   | YES   |
|---|---|
| Chiropractor <input type="checkbox"/>         | CT Scan <input type="checkbox"/>              |
| EMG/NCV <input type="checkbox"/>              | General Practitioner <input type="checkbox"/> |
| Massage Therapy <input type="checkbox"/>      | MRI <input type="checkbox"/>                  |
| Myelogram <input type="checkbox"/>            | Neurologist <input type="checkbox"/>          |
| Occupational Therapy <input type="checkbox"/> | Orthopedist <input type="checkbox"/>          |
| Physical Therapy <input type="checkbox"/>     | Podiatrist <input type="checkbox"/>           |
| Emergency Room Care <input type="checkbox"/>  | X-Rays <input type="checkbox"/>               |

Do you now have or have you ever had ANY of the following?

- |  |                          |   |                          |
|--|--------------------------|---|--------------------------|
| <b>Lungs:</b>  | <b>YES</b>               | <b>Cardiovascular:</b>                                    | <b>YES</b>               |
| Asthma <input type="checkbox"/>                        | <input type="checkbox"/> | High Blood Pressure <input type="checkbox"/>              | <input type="checkbox"/> |
| Bronchitis <input type="checkbox"/>                    | <input type="checkbox"/> | Shortness of Breath/ Chest Pain <input type="checkbox"/>  | <input type="checkbox"/> |
| Emphysema <input type="checkbox"/>                     | <input type="checkbox"/> | Heart Attack or Surgery <input type="checkbox"/>          | <input type="checkbox"/> |
| Tuberculosis <input type="checkbox"/>                  | <input type="checkbox"/> | Stroke/TIA <input type="checkbox"/>                       | <input type="checkbox"/> |
|  |                          | Coronary Heart Disease or Angina <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Orthopedic:</b>                                     | <b>YES</b>               | Blood Clot/emboli <input type="checkbox"/>                | <input type="checkbox"/> |
| Arthritis/Swollen Joints <input type="checkbox"/>      | <input type="checkbox"/> | Anemia <input type="checkbox"/>                           | <input type="checkbox"/> |
| Osteoporosis <input type="checkbox"/>                  | <input type="checkbox"/> | Do you have a pacemaker? <input type="checkbox"/>         | <input type="checkbox"/> |
| Gout <input type="checkbox"/>                          | <input type="checkbox"/> |   |                          |
| Any Pins or Metal Implants <input type="checkbox"/>    | <input type="checkbox"/> | <b>Other Systemic:</b>                                    | <b>YES</b>               |
| Neck Injury/Surgery <input type="checkbox"/>           | <input type="checkbox"/> | Diabetes <input type="checkbox"/>                         | <input type="checkbox"/> |
| Shoulder Injury/Surgery <input type="checkbox"/>       | <input type="checkbox"/> | Infectious Diseases <input type="checkbox"/>              | <input type="checkbox"/> |
| Elbow/Hand Injury Surgery <input type="checkbox"/>     | <input type="checkbox"/> | Thyroid Trouble/ Goiter <input type="checkbox"/>          | <input type="checkbox"/> |
| Weakness <input type="checkbox"/>                      | <input type="checkbox"/> | Cancer or Chemotherapy/Radiation <input type="checkbox"/> | <input type="checkbox"/> |
| Leg/Ankle/Foot Injury/Surgery <input type="checkbox"/> | <input type="checkbox"/> | Allergies <input type="checkbox"/>                        | <input type="checkbox"/> |
| Knee Injury/Surgery <input type="checkbox"/>           | <input type="checkbox"/> | Bowel or Bladder Problems <input type="checkbox"/>        | <input type="checkbox"/> |
| Back Injury/Surgery <input type="checkbox"/>           | <input type="checkbox"/> | Epilepsy/Seizures <input type="checkbox"/>                | <input type="checkbox"/> |
| Hernia <input type="checkbox"/>                        | <input type="checkbox"/> | Severe or Frequent Headaches <input type="checkbox"/>     | <input type="checkbox"/> |
| Other _____ <input type="checkbox"/>                   | <input type="checkbox"/> | Vision or Hearing Difficulties <input type="checkbox"/>   | <input type="checkbox"/> |
|  |                          | Numbness or Tingling <input type="checkbox"/>             | <input type="checkbox"/> |
|  |                          | Dizziness or Fainting <input type="checkbox"/>            | <input type="checkbox"/> |
|  |                          | Ring in Your Ears <input type="checkbox"/>                | <input type="checkbox"/> |

Please answer the following questions:

- |   |        |                                      |
|---|--------|--------------------------------------|
| Do you Smoke?   | Circle |                                      |
| Do you have Sleeping Problems or Difficulties?            | YES NO | QUIT (How long ago? _____)           |
| Do you have any Emotional or Psychological Problems?      | YES NO |                                      |
| (Women): Are you Pregnant?                                | YES NO | IF yes; what is your Due Date? _____ |
| Have you ever had to take any steroid medications?        | YES NO |                                      |
| Have you ever had to take any blood thinning medications? | YES NO |                                      |
| Do you understand your diagnosis?                         | YES NO |                                      |

Please list any other information that you feel would assist us in your care: \_\_\_\_\_

How did you hear about [INSERT CLINIC DBA NAME HERE]? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed with Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Evaluating Therapist's Initials)