

Medical History Questionnaire

(Insert Clinic DBA here)

Patient Name _____ Subscriber ID # _____ Primary Language _____

Occupation _____

Recreational Activities/Hobbies _____

Describe Your Current Problem and How It Began _____

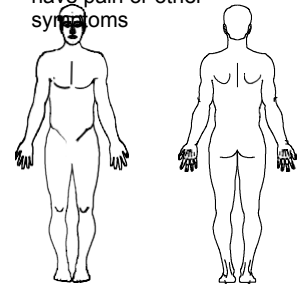
Onset date/Surgery date _____

Is this? Work Related Auto Related N/A

How often are your symptoms present?

Constantly (76-100% of the day) Occasionally (26-50% of the day)
Frequently (51-75% of the day) Intermittently (0-25% of the day)
Day) Day)

Indicate below where you have pain or other symptoms



Describe the nature of your symptoms:

Sharp Dull Ache Numb Shooting Burning Tingling

How is your condition changing?

Getting Better Not Changing Getting Worse

Current complaint (how you feel today):

No pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Unbearable pain

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

No interference | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Unable to carry on any activities

Who have you seen for your current condition before today?

No One

Medical Doctor Massage Therapist Chiropractor Other _____
 Physical Therapist Acupuncturist Occupational Therapist Speech Therapist Athletic Trainer

What treatment did you receive and when? _____

Have you had x-rays, MRI, CT Scan for your area(s) of complaint? Yes No

Date(s) taken _____ What areas were taken? _____

In general would you say your overall health right now is:

Excellent Very Good Good Fair Poor

Check if you have any difficulty with: Seeing Hearing Swallowing Speaking/Talking Memory

FAMILY HISTORY

Please check if anyone in your immediate family (parents, brothers, sisters) have ever been treated for any of the following:

Diabetes Cancer
 Heart Disease Inflammatory Arthritis (Rheumatoid, Ankylosing)
 Kidney Disease Stroke
 Chemical Dependency (i.e. Alcoholism) Depression
 Ehlers-Danlos Syndrome Osteoporosis

Medical History Questionnaire

Please check all of the following that apply to you:

- | | | |
|---|--|--|
| <input type="checkbox"/> Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Ehlers-Danlos Syndrome |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Stroke/CVA (Date) _____ | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Other Arthritic Conditions | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Asthma | <input type="checkbox"/> Alcohol/Drug Dependence |
| <input type="checkbox"/> Recent Fever | <input type="checkbox"/> Emphysema/Bronchitis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Osteoporosis | | |
| <input type="checkbox"/> Cancer | If Yes, describe what kind & treatment _____ | |
| <input type="checkbox"/> Heart Problems | If Yes, describe what kind & treatment _____ | |
| <input type="checkbox"/> Kidney Problems | If Yes, describe what kind & treatment _____ | |

OTHER CONDITIONS

Please check any of the below that you have experienced in the **last 12 months?**

- | | | |
|---|---|---|
| <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Joint/Muscle Swelling | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Problems Sleeping |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Sexual Difficulties |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Regular Cough | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Fever/Chills/Sweats | <input type="checkbox"/> Arm/Leg Swelling | <input type="checkbox"/> Problems Urinating |
| <input type="checkbox"/> Stress at Home or Work | <input type="checkbox"/> Heart Racing in your Chest | <input type="checkbox"/> Fecal Incontinence |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Difficulty Swallowing | |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Heartburn/Indigestion | |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Constipation/Diarrhea | |
| <input type="checkbox"/> Loss of Vision | <input type="checkbox"/> Blood in Stool | |
| <input type="checkbox"/> Eye Redness | <input type="checkbox"/> Blood in Urine | |

ALLERGIES: List any medications that you are allergic to: _____

Are you latex sensitive? Yes No

List any other allergies we should know about: _____

How much caffeinated coffee or other caffeinated beverages do you drink per day? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer or one glass of wine, how much do you drink at an average sitting? _____

Are you now, or have you ever been, a smoker? Yes No

If Yes, how many packs of cigarettes do you smoke a day? _____

Have you ever taken an anticoagulant? Yes No

Do you have a pacemaker? Yes No

Have you ever taken steroid medications for any reason? Yes No

During the past month, have you been feeling down, depressed, or hopeless? Yes No

During the past month, have you been bothered by having little interest or pleasure in doing things? Yes No

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? Yes No

Are you currently pregnant or think you might be pregnant? Estimated Delivery Date? _____ Yes No

Medical History Questionnaire

Please list all surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for surgery or hospitalization	
Date	Reason for Surgery/Hospitalization
1.	
2.	
3.	
4.	
5.	
6.	

Please list all significant injuries for which you have been treated (including fractures, dislocations, sprains/strains) and the approximate date(s) of injury	
Date	Description of Injury
1.	
2.	
3.	
4.	
5.	
6.	

Medical History Questionnaire

CURRENT MEDICATIONS

Please list **ALL** medications (INCLUDING prescription, over-the-counter, herbals, vitamin/mineral/dietary (nutritional) supplements, injections, and/or skin patches) that you are **currently** taking. For each medication, please list the name, dosage, frequency, and route (by mouth, inhaler, intravenously, topically, etc.). You may attach a copy of your own list of medications if available. Only fill out the post-surgery medications if this section applies to you.

Current Medications:

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Post-Surgery Medications:

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

Medication: _____
Dosage: _____ Frequency: _____
Route: _____

****During the course of your Physical Therapy, if there are any changes (type or dosage) in your medications or supplements, it is important that you notify your therapist!****

I certify to the best of my knowledge, that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider/ practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this provider/ practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that this provider/practitioner may need to contact my physician if my condition needs to be co- managed. Therefore, I give authorization to this provider/practitioner to contact my physician, if necessary.

Patient/Responsible Party Signature: _____ **Date:** _____

Reviewed with Patient: _____ **Date:** _____

Evaluating Physical Therapist's Signature