

Medical History/Questionnaire

Please print all information.

Patient Name _____

What body part(s) are you seeking treatment for? _____ Right Left

What is the main reason for this visit? Pain Numbness Weakness Swelling Stiffness Other _____

When did your symptoms begin? __/__/_____

Have you had surgery for this injury? Yes No Type of Surgery _____ Date _____

Have you previously had physical therapy for this injury? Yes No If yes, what company? _____

On a scale of 1-10 (10 being the worst) how severe is your pain? (circle) 1 2 3 4 5 6 7 8 9 10

How would you describe your pain? Sharp Dull Stabbing Throbbing Aching Burning

What do you expect to gain/accomplish from receiving physical therapy?

List any operations or surgeries you have had:

List any medications you are currently taking:

List any allergies and describe any drug reactions:

Do you currently have any of the following? Check all that apply. **If none apply check here**

- | | |
|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Weight Loss/Energy Loss |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Any Pins or Metal Implants |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Arthritis/Swollen Joints | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Severe or Frequent Headaches | <input type="checkbox"/> Numbness or Tingling |
| <input type="checkbox"/> Dizziness or Faintness | |

TO THE BEST OF MY KNOWLEDGE, INFORMATION PROVIDED IS CORRECT

Signature _____

Date _____