PATIENT QUESTIONNAIRE/MEDICAL HISTORY

Full Name: Date:

Street Address:

City: Zip: Telephone:

Preferred email: Date of Birth:

Hand Dominance: Left Right Age Height Weight

EMPLOYMENT HISTORY

Are you presently employed ? ☐ Yes ☐Full-Time ☐Part-Time

☐No ☐Unemployed ☐Disabled ☐Retired

If yes, brief job description:

Job Requirements: ☐Sitting ☐Standing ☐Bending ☐Twisting ☐Lifting

PRESENT CONDITIONS INFORMATION

What is the reason for your Physical Therapy visit today?

Did a physician refer you to PT for this pain episode? ☐Yes ☐ No If yes, referring physician:

When do you return to the referring physician?

Is this pain episode related to (circle one) ☐Work ☐MVA ☐Surgery ☐ Unknown Other:

Was this due to an injury? ☐Yes ☐ No Date of injury? Onset of Symptoms

Please describe the injury or what you

were doing when the symptoms began:	
What are your current symptoms?	

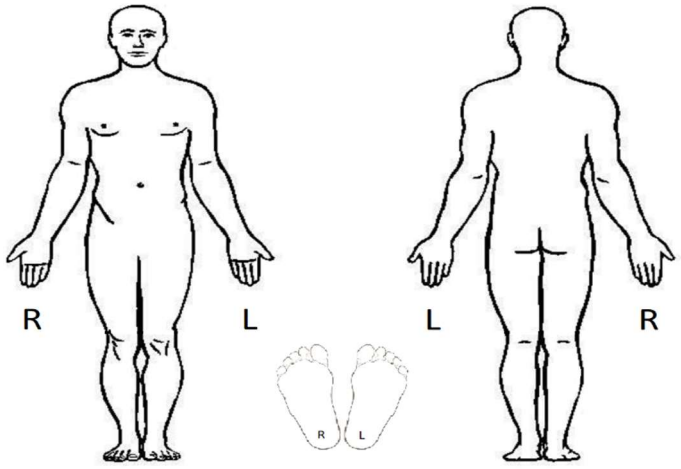
Please rate the intensity of your **current, best and worst** pain levels over **the past 24 hours**:	**NO PAIN**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**WORST**

	Current:	Best:	Worst:
What activities/positions increase your symptoms?			
What activities/positions decrease your symptoms?			
Describe any specific tasks or other day-to-day activities (personal, professional, recreational) that are being adversely affected:			

Are you currently receiving any other treatment(s) for this problem?	☐ Yes	☐ No	If Yes, please describe:
If Yes, have you received physical therapy for this in the past?	☐ Yes	☐ No	If Yes, number of total visits:
Have you had any diagnostic testing for this problem (i.e. x-ray, MRI, CT scan, etc)?	☐ Yes	☐ No	

Type of Test	Date	Results

What are your primary goals for physical therapy?



On the image to the right, please shade in the areas where you have pain.

PERSONAL HISTORY / HEALTH HISTORY

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other

Do you exercise regularly? ☐Yes ☐No How often? What activities?

What are your hobbies / leisure activities?

Please list your prescribed and over-the-counter medications (inlcuding vitamins, herbal supplements, etc):

Medication	Dosage / Strength	Frequency	Medication	Dosage / Strength	Frequency

Have you ever been treated for, or are you presently experiencing any of the following?

Allergies	☐Yes	☐No	Hemorrhoids	☐Yes	☐No
Anxiety or Panic Disorders	☐Yes	☐No	High Blood Pressure	☐Yes	☐No
Arthritis (RA, OA)	☐Yes	☐No	Irritable Bowel Syndrome	☐Yes	☐No

Bowel / Bladder Abnormalities (including Constipation)	☐Yes	☐No	Joint Dislocation	☐Yes	☐No
Breathing Problems (Asthma, COPD, etc.)	☐Yes	☐No	Kidney Problems	☐Yes	☐No
Cancer	☐Yes	☐No	Metal Implants	☐Yes	☐No
Chronic Fatique Syndrome	☐Yes	☐No	Multiple Sclerosis	☐Yes	☐No
Degenerative Disc Disease (back disease, spinal stenosis, sever chronic back pain)	☐Yes	☐No	Nausea / Vomiting	☐Yes	☐No
Depression	☐Yes	☐No	Numbness / Tingling	☐Yes	☐No
Diabetes	☐Yes	☐No	Osteoporosis / Ostepenia	☐Yes	☐No
Dizzy or Fainting Spells	☐Yes	☐No	Parkinson's Disease	☐Yes	☐No
Epilepsy or Seizure Disorder	☐Yes	☐No	Pacemaker / Defibrillator	☐Yes	☐No
Fever	☐Yes	☐No	Pelvic Floor Dysfunction	☐Yes	☐No
Firbromyalgia	☐Yes	☐No	Ringing in your ears	☐Yes	☐No
Fracture	☐Yes	☐No	Sleep Apnea	☐Yes	☐No
Gastrointestinal Disease (ulcer, hernia, reflux)	☐Yes	☐No	Stroke or TIA (transient ischemic attack)	☐Yes	☐No
Hearing impairment	☐Yes	☐No	Surgery	☐Yes	☐No
Headaches	☐Yes	☐No	Unexplained Weight Loss	☐Yes	☐No
Heart Problems	☐Yes	☐No	Vertigo	☐Yes	☐No
Hemophilia	☐Yes	☐No			

Please describe any "YES" responses from the previous table:

Please describe any other
pertinent medical information: