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|  | | | | | | | | | | | | | | | | | | | | | | | | PATIENT QUESTIONNAIRE/MEDICAL HISTORY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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? | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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? | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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 PAIN IMAGINABLE** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | 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 | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| What are your primary goals for physical therapy? | | | | | | | | | | | | | | | | | | | | | | | | A diagram of a human body  Description automatically generated with medium confidence | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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 | | | | | | | |
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| 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: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  |
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| Please describe any other pertinent medical information: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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