|  |  |
| --- | --- |
|  | 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 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 |  |
|  |  |  |
|  |  |  |
| What are your primary goals for physical therapy? | A diagram of a human body  Description automatically generated with medium confidence |
|  |
|  |
|  |
|  |
|  |
|  |
| 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: |  |
|  |
|  |