

Medical Questionnaire – Physical Therapy

Patient Name _____ **Date** _____

1. What problem or diagnosis brings you to this Physical Therapy office? _____
2. To the best of your knowledge, what was the date of your injury or surgery? ____/____/____
3. If this was an injury, please check the appropriate box.
 Motor vehicle accident Work Injury Sports Unknown Other (please describe) _____
4. Have you received physical therapy before? Yes No If so, how long ago? _____
5. I have had the following tests: X-ray MRI CT EMG Other _____
6. Do you have any numbness or tingling? Yes No
7. Is your pain affecting your ability to sleep through the night? Yes No
8. Does coughing or sneezing increase your symptoms? Yes No
9. Do you smoke? Yes No If so, how many packs per day? _____
10. Rate your pain on a scale from 0 to 10 with 0 = NO PAIN and 10 = WORST PAIN you can imagine.
 The best it has been since the injury _____. The worst it has been since the injury _____. Your Pain today _____.
11. What makes your pain feel BETTER? _____
12. What makes your pain feel WORSE? _____
13. What do you hope to gain from physical therapy? _____

Medications

Current Medications: _____

Current Vitamins/Supplements: _____

Medical History (Check any that apply)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Frequent Falls | <input type="checkbox"/> Major Spinal Injury |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Chest/Abdominal Surgery | <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Pacemaker/Nitroglycerin |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Poor Circulation/Raynaud's |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Herpes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Severe Night Pain |
| <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Bruising Easily | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Traumatic Injury/MVA |
| <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Menopause | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Fractures | <input type="checkbox"/> Migraine Headaches | _____ |

Signature _____ Date _____