Medical History Questionnaire

The purpose of this questionnaire is to help us understand your health status. Please complete this form and your therapist will answer any questions during your exam. This form is considered part of your medical record.

Name:_____ D.O.B./Age_____/_____

Referring Physician:_____ Family Physician:_____

Emergency Contact Name:_____ Phone:_____Cell:_____

Date of Last General Health Check-up:_____/_____/_____Occupation:_____

Last Day Worked Due to Injury:_____/_____/_____Date Returned to Work After This Injury:_____/_____/_____

Have you had Surgery for this Injury? YES NO Type of Surgery/Date:_____

Is an Attorney Involved in this Case? YES NO Attorney Name:_____

Pain: Please Circle your Current Pain Level Intensity (0=no pain, 10=Emergency room pain(max pain)

0 1 2 3 4 5 6 7 8 9 10

My Pain can be Described as: (please circle all that apply)

Constant Intermittent Sharp Dull Aching Stabbing Numbness Pins/Needles

Are you Currently Taking Any Prescriptions or Non-Prescription Medications? YES NO

Anti-Inflammatories Muscle Relaxers Pain Medication Others:_____

Have you had any of the following Medical or Rehabilitative Care for this Injury/Episode? If yes, When?_____

	YES	NO		YES	NO
Chiropractor	___	___	CT Scan	___	___
General Practitioner	___	___	EMG/NCV	___	___
Occupational Therapy	___	___	MRI	___	___
Physical Therapy	___	___	Myelogram	___	___
Massage Therapy	___	___	X-Rays	___	___
Neurologist	___	___	Emergency room care	___	___
Orthopedist	___	___	Podiatrist	___	___

Do you have, or have you ever had any of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	___	___	Severe/Frequent Headaches	___	___
Shortness of Breath	___	___	Vision or Hearing problems	___	___
Coronary Heart Disease	___	___	Numbness/Tingling	___	___
Pacemaker	___	___	Dizziness/Fainting	___	___
High Blood Pressure	___	___	Weakness	___	___
Heart Attack/surgery	___	___	Weight Loss	___	___
Blood clot	___	___	Hernia	___	___
Stroke	___	___	Epilepsy/Seizures	___	___
Pins/Metal implants	___	___	Thyroid Trouble	___	___
Joint Replacement	___	___	Incontinence	___	___
Diabetes	___	___	Bowel/Bladder Problems	___	___
Infectious Disease	___	___	Neck Injury/Surgery	___	___
Cancer	___	___	Upper Extremity Injury/Surgery	___	___
Arthritis	___	___	Lower Extremity Injury/Surgery	___	___
Osteoporosis	___	___	Back Injury/Surgery	___	___
Do you Smoke?	___	___	Multiple Sclerosis	___	___
Latex Allergy	___	___	Are you Pregnant(Female only)	___	___
Sleeping Difficulty	___	___	Complicated pregnancy	___	___
Pelvic Inflammatory Disease	___	___	Irregular Menstrual Cycle	___	___

Patient/Guardian Signature:_____ Date:_____

PT Initials_____ Date:_____