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: _____

Date of Last General Health Check-up: _____/_____/____ Occupation: _____

Last Date Worked Due to this Injury: _____/_____/_____ Date Returned to Work after this Injury: ____/_____/_____

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

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

Pain (please draw a vertical line where you would rate your pain intensity): 0----------5----------10
No pain Maximum Pain Tolerable

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 Prescription or Non-Prescription Medications? YES NO
□ Anti-Inflammatories □ Muscle Relaxers □ Pain Medicines □ Other: _____

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	____	____	Myclogram	____	____
Message Therapy	____	____	X-Rays	____	____
Neurologist	____	____	Emergency Room Care	____	____
Orthopedist	____	____	Podiatrist	____	____

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

	YES	NO		YES	NO
Asthma, Bronchitis or Emphysema	____	____	Severe of Frequent Headaches	____	____
Shortness of Breath/Chest Pain	____	____	Vision of Hearing difficulty ____	____	
Coronary Heart Disease or Angina	____	____	Numbness of Tingling	____	____
Do you have a Pacemaker	____	____	Dizziness or Fainting	____	____
High Blood Pressure	____	____	Weakness	____	____
Heart Attack/Heart Surgery	____	____	Weight Loss/Energy Loss	____	____
Blood Clot/Emboli	____	____	Hernia	____	____
Stroke/TIA	____	____	Epilepsy/Seizures	____	____
Allergies	____	____	Thyroid Trouble/Goiter	____	____
Pins or Metal Implants	____	____	Incontinences	____	____
Joint Replacement (any joint)	____	____	Bowel or Bladder Problems ____	____	
Diabetes	____	____	Neck Injury/Surgery	____	____
Infectious Diseases	____	____	Shoulder Injury/Surgery	____	____
Cancer/Chemotherapy/Radiation	____	____	Elbow/Hand Injury/Surgery ____	____	
Arthritis/Swollen Joints	____	____	Back Injury/Surgery	____	____
Osteoporosis	____	____	Knee Injury/Surgery	____	____
Sleeping Problems/Difficulty	____	____	Leg/Ankle/Foot Injury/Surgery	____	____
Do you smoke?	____	____	Multiple Sclerosis/Parkinson's	____	____
Latex Sensitivity/Allergy	____	____			

FOR WOMEN ONLY:	YES	NO		YES	NO
Pelvic inflammatory disease	____	____	Endometriosis	____	____
Irregular Menstrual Cycle	____	____	Incontinence (urinary/fecal)	____	____
Complicated pregnancies/deliveries?	____	____	Are you pregnant?	____	____

Patient/Guardian Signature: _____ Date: _____

PT Initials: _____ Date: _____