** MEDICAL QUESTIONNAIRE**

**Patient Name:**

**What problem/diagnosis brings you here today?**

**Side of Injury [ ]  R [ ]  L Date of Injury: Date of Surgery**

**Have you received therapy for this condition before? yes no**

**Have you received outpatient therapy services this calendar year? (indicate # of visits) PT OT**

**Have you had a similar condition before? [ ]  yes [ ]  no If yes, when?**

**Is this injury/condition related to an incident in which another party may be responsible? Circle one: workers compensation / No Fault motor vehicle accident / other**

**If so, whom is suspected of being responsible?**

**Claim #:**

 **Contact/Adjuster Name/Phone #:**

 **Case Manager Name/Phone#:**

**Have you hired or plan to hire an attorney to represent you in connection with this injury or illness?**

 **Name of Attorney**

 **Address/Phone:**

**Describe how this injury/condition occurred:**

**Current occupation:** **[ ] Regular Duty** **[ ] Light Duty**

**Shade areas of your pain/discomfort on the figure to the left**

**Rate your pain on a scale from 0-10 (0=no pain;10=emergency room )**

**Current ○ 0 ○ 1 ○ 2 ○3 ○4 ○5 ○ 6 ○ 7 ○8 ○9 ○10**

**At best ○ 0 ○ 1 ○ 2 ○3 ○4 ○5 ○ 6 ○ 7 ○8 ○9 ○10**

**At worst○ 0 ○ 1 ○ 2 ○3 ○4 ○5 ○ 6 ○ 7 ○8 ○9 ○10**

**What makes your pain better:**

**What makes your pain worse:**

**What activities at home, work or recreation are you unable to perform?**

**Goals for therapy:**

**Current medications:**

**Allergies:**