Tyler PHYSICAL THERAPY & PILATES

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Confidential Medical Questionnaire

Patient Name: _____

•What Medications are you currently taking? (Please include dosage)

_____

_____

_____

- Do you have any of the following conditions? (Check all that apply)

___Heart Disorder ___Pacemaker ___Diabetes ___High Blood Pressure
___Cancer ___Metal Implants ___Kidney Disorder ___Respiratory Disorder
___Headaches ___Vision Disorder ___Alcohol/Drug ___Incontinence
___Arthritis ___Hearing Disorder ___Depression ___Allergies

- Present condition began when?

_____

- Have you had surgery for this condition? ___YES ___NO
  If yes, date of surgery: ____ / ____ / _____
- Previous treatment for this condition? ___YES ___NO
  If yes Date: ____ / ____ / _____ Treatment: _____
- Have you had this condition previously? ___YES ___NO
- Symptoms came on? ___Gradually ___Suddenly
- Are your symptoms? ___Constant ___Intermittent
- Diagnostic tests done? ___X-rays ___MRI ___CT Scan ___NVC Test ___Other
- Signs and Symptoms? (Check all that apply)
  ___Dizziness ___Weakness ___Numbing ___Pain ___ Tingling ___Burning ___Headache
- What decreases your symptoms?

_____

- What increases your symptoms?

_____

- When do you feel better?

_____

- When do you feel worse?

_____

- Daily activities affected by this condition? (Check all that apply)
  ___Sitting ___Standing ___Stairs ___Walking ___Sleeping ___Driving ___Lifting ___Reaching
  ___Writing ___Eating ___Bathing ___Sports
- What are your goals for physical therapy?

_____

Pain Scale

Circle the number that indicates your pain
0 = no pain at all
10 = need to call 911/emergency pain

- Today? 1 2 3 4 5 6 7 8 9 10
- Worst? 1 2 3 4 5 6 7 8 9 10
- Least? 1 2 3 4 5 6 7 8 9 10

- Circle on the Body Chart Picture where the pain occurs.

Body Chart