BEAT Physical Therapy
Movement Specialists

PATIENT DATA AND MEDICAL HISTORY QUESTIONNAIRE

NAME (Last, First): _____

DOB: _____ GENDER: □ M □ F MARITAL STATUS: _____

ADDRESS: _____

CONTACT #: _____ EMAIL: _____

PRIMARY INSURANCE: _____ □ CARD ON FILE

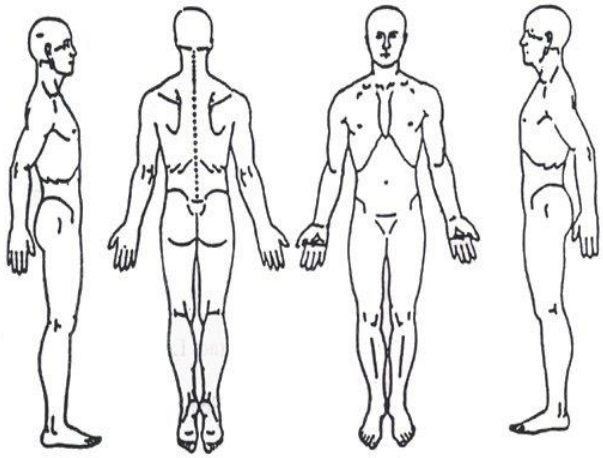
PRIMARY CARE MD: _____ PHONE #: _____

REFERRING MD (IF DIFFERENT): _____ PHONE #: _____

*** Answering this questionnaire in detail will help your therapist identify how they can help you and be able to set the best plan of treatment possible. Thank you!*

HISTORY OF PRESENT ILLNESS:

Please mark with "X" in the diagram where you feel your symptoms and label it using descriptors below:



PAIN DESCRIPTION (please encircle): Sharp; aching; shooting; burning; throbbing

OTHERS: pins and needles; numbness; weakness; swelling; discomfort; stiffness; tightness

Are your symptoms due to work-related injury?
□ Yes □ No
Are your symptoms from a car accident?
□ Yes □ No

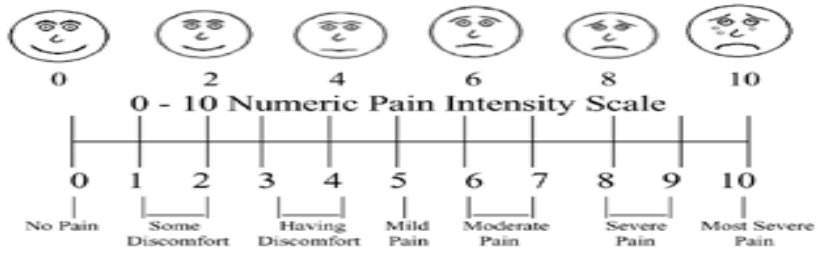
How long have you had your symptoms?
□ Less than 1 week □ Less than 1 month
□ 1-3 months □ More than 3 months
If known, please write exact date of injury:
_____ / _____ / _____
Did you have surgery for this condition?
□ Yes □ No
If yes, when? _____/ _____/_____

What activities do you have problems with because of your current symptoms?
_____
_____
_____

Are your symptoms:
□ Constant? (present with same intensity all the time)
□ Continuous? (present all the time but varies in intensity)
□ Intermittent? (on and off)

What makes your symptoms worse?
_____
What relieves your symptoms?
_____

PLEASE MARK YOU PAIN LEVEL ON THE SCALE BELOW



Identify the following pain levels:

- "A" – At PRESENT
- "B" – At WORST in the past 2 weeks
- "C" – At BEST in the past 2 weeks

TREATMENTS OR IMAGING RECEIVED FOR CURRENT CONDITION: (Check "√" all that apply):

	Physical Therapy		X-ray / Plain Films	Other Treatments (please list):
	Chiropractor		MRI	
	Primary Care Doctor		CT-Scan	
	Orthopedic MD		Blood Tests	Other Tests (please list):
	Occupational therapy		Acupuncture	

PAST MEDICAL AND SURGICAL HISTORY: (Check "√" all that apply):

Weight: _____lbs. Height: _____Ft _____inches □ R-handed □ L-handed

General health in the past 6 months. Have you had the following?

Fatigue	□ Yes □ No	Fever, Chills, Sweats	□ Yes □ No
Malaise (general discomfort)	□ Yes □ No	Unexplained weight change (5-10% of weight)	□ Yes □ No
Nausea and Vomiting	□ Yes □ No	Dizziness or Lightheadedness	□ Yes □ No

(Check "√" all that apply)	Personal	Family	(Check "√" all that apply)	Personal	Family
Arthritis			Depression / Anxiety		
Lupus			Stroke		
Gout			Urinary or Fecal Incontinence		
Fibromyalgia			Parkinson's Disease		
Osteoporosis			Multiple Sclerosis		
Blood Clots			COPD / Emphysema / C. Bronchitis		
Epilepsy			Asthma		
Migraines			Heart Attack / Myocardial Infarct		
Hypertension			Hyper/Hypothyroid		
High Cholesterol			Pacemaker		

(Check "√" all that apply)	Personal	Family	If "√", Please specify (When and type):
Cancer			When and Type: _____ Treatment: □ Chemotherapy □ Radiation □ Surgery
Diabetes			Type: □ Type I □ Type II
Chemical dependency			When: _____ □ Alcohol □ Drug □ Others: _____
Hepatitis			Type: □ A □ B □ C
Fractures (Broken Bone)			Body Part: _____ When: _____

(Check "√" all that apply)		If "√", Please specify (type and when diagnosed):
	Infection	Past 12 months: _____
	Allergies	Medication: _____ □ Latex □ Adhesives Others:_____
Other Medical Conditions not listed previously: _____ _____		

LIST ALL SURGICAL PROCEDURES AND DATE:

_____

_____

_____

MEDICATIONS

In the past week, have you taken any of the following medications?
(Check "√" all that apply)

	Muscle Relaxers		Pain Reliever	Others including supplements and over-the-counter meds: (Please list)
	Anti – inflammatory		Nerve Block	
	Anti – Hypertensives		Anti – Cholesterol	_____
	Diabetes Medication		Antibiotics	_____
	Birth Control Pills		Anti – Depressants	_____

I have provided a detailed list of my current medications: □ Yes □ No

FOR WOMEN ONLY

(Check "√" all that apply)

	Pelvic inflammatory disease		Endometriosis	Other Gynecologic Conditions:
	Irregular Menstrual cycle		Postmenopausal	_____

Are you pregnant? □ Yes □ No; If yes, how many weeks? _____
Do you have any children? □ Yes □ No; If yes, how many? _____

ADDITIONAL HEALTH INFORMATION:

1) Tobacco Use: □ Yes □ No; If yes, how many packs consumed per day? _____

   For how many years? _____; if you quit, since when? _____

2) Are you an alcoholic-beverage drinker? □ Yes □ No

   If yes, please mark frequency and amount: □ Occasional □ Daily □ 1-3 glasses per weekk □ 4-6 glasses per week

3) How many of glasses of water do you drink per day? □ 0 □ 1-4 □ 5-8 □ 9-12 □ > 12

4) How many cups of caffeinated beverages do you drink per day? □ 0 □ 1-4 □ 5-8 □ 9-12 □ > 12

5) How many hours of sleep do you have per day? □ 0 □ 1-4 □ 5-8 □ 9-12 □ > 12

6) How will you rate your current diet? □ Excellent □ Very Good □ Good □ Fair □ Poor

7) Do you exercise? □ Yes □ No; If yes, what type? _____

   How often per week? _____ Do you work with a personal trainer? □ Yes □ No

8) How will you rate your overall health? □ Excellent □ Very Good □ Good □ Fair □ Poor

OTHER PATIENT INFORMATION:

Current Occupation: _____
If work-related injury, have you lost time from work? □ Yes □ No; If yes, since when? ___/___/_____

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form; and I had the opportunity to ask questions regarding the information on this form.

Patient Signature: _____ Date: ____/____/ _____

Printed Name of Patient: _____

Name of Representative (if applicable): _____

Thank You!!!!