MEDICAL QUESTIONNAIRE

Medical Questionnaire

Patient Name:_____ Date_____ Date of Birth_____Age____

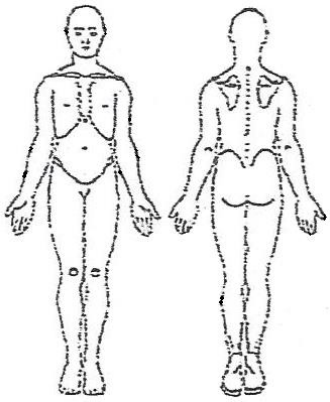
Occupation:_____ Employer:_____ Hrs/Wk_____

What problem or diagnosis brings you here today?_____

Side of Injury: ○ R ○ L Date of Injury?_____ Who referred you to PT?_____

Briefly describe your symptoms:_____

Describe how your condition or injury occurred:_____



Shade your areas of pain or discomfort on the figures to the left:

Please rate your pain on the scale below from 0 to 10:
(0=no pain; 10=worst pain imaginable/emergency room pain)

Pain at rest: ○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

Pain with activity: ○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

What is the frequency of your pain? ○Constant ○Intermittent

Does your pain wake you at night? ○Y ○N

How many times?_____

What eases your symptoms?_____

What aggravates your symptoms?_____

Are your symptoms getting ○Better ○Worse ○Same Is your pain worse in the ○AM ○PM ○Mid-Day

Are you currently working? ○Y ○N Are you currently on: ○Light duty ○Normal Duty

Is this a Motor Vehicle claim? ○Y ○N

What activities at home, work or recreational are you unable to perform?_____

Have you had a similar condition before? ○Y ○N If yes, when_____

Have you had tests for this condition? ○Y ○N If yes, results:_____

CIRCLE tests: X-Rays MRI Bone Scan CT Scan Nerve Tests Blood Tests Other_____

Have you had any other treatment for this condition? ○Y ○N

If yes, what Kind? ○PT ○OT ○Chiropractic ○Massage

CIRCLE Current Level of Physical Activity: High Medium Low List:_____

What goals do you hope to accomplish with Physical Therapy?_____

Medical History (Check all that apply)

☐ Angina/Chest Pain	☐ Cancer	☐ Hearing Problems	☐ Osteoporosis
☐ Asthma	☐ Depression	☐ Heart Disease	☐ Pacemaker/Nitroglycerin
☐ Arthritis	☐ Diabetes	☐ Hepatitis	☐ Poor Circulation/Raynaud's
☐ Blackouts	☐ Diverticulitis	☐ High Blood Pressure	☐ Polio
☐ Blindness	☐ Ear Infections	☐ High Cholesterol	☐ Seizures
☐ Blood Clot	☐ Endometriosis	☐ Hypoglycemia	☐ Stroke
☐ Bowel or Bladder Problems	☐ Fibroids	☐ Menopause	☐ TB
☐ Carpel Tunnel Syndrome	☐ Fibromyalgia	☐ Migraine Headaches	☐ Traumatic Injury/MVA
☐ Chest/Abdominal Surgery	☐ Fractures	☐ Major spinal issues	☐ Other
☐ Coronary Artery Disease	☐ Frequent Falls	☐ MRSA	

Are you Pregnant? ○Y ○N

Do you have a history of whiplash or low back pain? ○Y ○N If so, when/how long?_____

Do you smoke tobacco? ○Y ○N If yes, how much?_____ How long?_____

Medications/Allergies/Surgeries

List current medications:_____

List current allergies:_____

List all surgeries:_____

Signature_____ **Date**_____