Medical History Questionnaire

The purpose of this questionnaire is to help us understand your health status. Please complete this for and your therapist will answer any questions during your exam. This form is considered part of your medical record.

Name: ______________________________________ DOB/Age: _______/_______

Referring Physician: ___________________________ Family Physician: ___________________

Emergency Contact Name: ______________________________ Cell: ____________________

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/Date: ______________________

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 StabbingNumbness Pins/Needles

Are you currently taking any prescription or non-prescription medications? YES NO

Anti-inflammatories Muscle Relaxers Pain Medicines Others: ___________________

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	_____	_____	Myelogram	_____	_____
Massage Therapy	_____	_____	X-Rays	_____	_____
Neurologist	_____	_____	Emergency Room Care	_____	_____
Orthopedist	_____	_____	Podiatrist	_____	_____

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

	YES	NO		YES	NO
Asthma, Bronchitis or Emphysema	_____	_____	Severe or Frequent Headaches	_____	_____
Shortness of Breath/Chest Pain	_____	_____	Vision or hearing difficulty	_____	_____
Coronary Heart Disease or Angina	_____	_____	Numbness or 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	_____	_____	Incontinence	_____	_____
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/Angle/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 Signature: ______________________________________ Date: ______________

PT Initials _________ Date: _________