**Medical Questionnaire**

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_ Gender: Female/Male Height: \_\_\_\_\_ Weight: \_\_\_\_\_\_

I certify that to the best of my knowledge the information below is accurate. I understand that it is my responsibility to inform my therapist immediately if there is any significant change in this information or my condition. I am aware that my diagnosis and treatment plan will be discussed and that I have the right to refuse any treatment offered.

**Past Medical History (Please circle all that apply)**

Angina/Chest Pain Allergies/Asthma Cancer Cataracts Dizziness/Vertigo

Diabetes Fibromyalgia Gout Heart Disease High Blood Pressure

Hearing Loss Incontinence Kidney Disease Lung Disease Liver Disease

Myofascial Pain Neuropathy Numbness Osteoporosis Osteoarthritis

Pins and Needles Reflux/GERD Stroke Spasm Rheumatoid Arthritis

Skin Disease Trigger Points Ulcers Surgeries Pregnancy

Are you a smoker: Yes No Are you Pregnant: Yes No

Are you allergic to latex: Yes No Do you take blood thinners: Yes No

Are you taking a Statin drug: Yes No Are you taking High Blood Pressure Medication: Yes NO

Are you Right of Left Handed: \_\_\_\_\_\_\_\_\_\_\_\_\_

List all prescription and over the counter medications you are taking, including the dosage and frequency:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any falls within the past year? Yes or No. If yes, how many? Any falls prior to this year? Any injuries from falls?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Injury/Onset (Please Complete All Fields – Information Required by Insurance)**

Is Injury Related to Auto Accident: Yes/No Is Injury Related to Work: Yes/No Date of Injury: \_\_\_\_\_\_\_\_\_\_

What Body Part: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Cause of Injury: \_\_\_\_\_\_\_\_\_\_\_ Date of Surgery: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Have you had prior physical therapy: Yes/No What Body Part: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When: \_\_\_\_\_\_

Describe current symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain Rating: \_\_\_\_\_\_ out of 10 (0 out of 10 = no pain 10 out of 10 is the worst pain imaginable)

Other current symptoms other than pain: (circle all that apply)

Changes in bowel or bladder Change in Appetite Depression Dizziness Difficulty Swallowing

Fever/Chills Headache Night Sweats Numbness Nausea/Vomiting Poor Balance Shortness of Breath Pins and Needles/Tingling Difficulty Sleeping

Please indicate the number which describes your current level of function: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(unable to do anything = 0 and able to do everything = 10)

What makes symptoms worse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes symptoms better: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had an X-ray, MRI, EMG or other scan done? Yes or No

If yes, which \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Have you ever had a cortisone injection or taken steroid pills? Yes or No

If yes, which \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Signature of Patient or Responsible Person:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_