MEDICAL QUESTIONNAIRE

Medical Questionnaire – Physical Therapy

Patient Name _____ Date _____ Date of Birth _____ Age _____

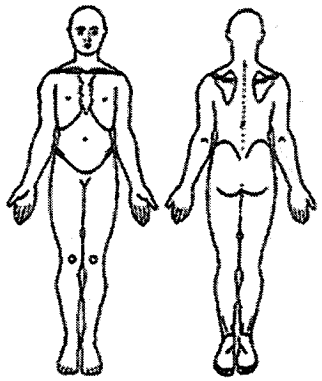
Occupation _____ Employer _____ Hrs/Wk _____

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: _____

Check 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

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

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

Medical History (Check any that apply)

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

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 _____