



MEDICAL HISTORY QUESTIONNAIRE

Past Medical History (Section 1)

Please check if you have you ever had any of the following:

- List of medical conditions with checkboxes: High Blood Pressure, Heart Disease, Heart Surgery, Pacemaker, Cancer, Internal Metal Plates / Screws, Thyroid Problems, Depression, Dizziness, Headaches, Diabetes, Balance Coordination Problems, Kidney Problems, Hearing Loss, Arthritis, Osteoporosis, Stroke, Neurologic Problems, Heart Attack, Surgeries, Athsma, Anxiety, Hernia, Substance Abuse, Vascular Disease, Presently Pregnant.

Please list out any other significant past medical history and types of surgeries:

Are you currently under a physician's care for any of the above conditions? \_ Yes \_ No

Condition: \_\_\_\_\_ Physician: \_\_\_\_\_ Condition: \_\_\_\_\_ Physician: \_\_\_\_\_

Please list known allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Current Exercise Program / Diet: \_\_\_\_\_

Current Condition (Section 2)

Have you sought treatment from any other healthcare professionals other than your referring physician? \_ Yes \_ No

If Yes: \_ Primary Care \_ Specialist \_ Chiropractor \_ Other Rehabilitation Professional \_ Other: : \_\_\_\_\_

Are you presently under the care of one of these providers for your current condition? \_ Yes \_ No

What types of treatments have you had for this condition:

\_ Medications \_ Injections \_ Surgery \_ Physical Therapy / Rehabilitation \_ Other: \_\_\_\_\_

What helps relieve your current symptoms? \_\_\_\_\_

What makes your symptoms worse? \_\_\_\_\_

Which best describes the pain you experience? \_ Aching \_ Sharp \_ Burning \_ Stabbing \_ Shooting/Radiating \_ Numbness or Tingling \_ Nagging

How often do you experience some level of pain? \_ 100% \_ 75% \_ 50% \_ 25% or less

On a scale of 0 - 10 (0 = no pain and 10 = excruciating pain requiring emergency assistance): Check level of pain over last week:

Worst Point: \_0 \_1 \_2 \_3 \_4 \_5 \_6 \_7 \_8 \_9 \_10 Least Point: \_0 \_1 \_2 \_3 \_4 \_5 \_6 \_7 \_8 \_9 \_10

Your current condition limits your ability to perform which of the following activities? (Please check all that apply)

Table with 5 columns: Ambulation, Transfers / Positioning, Activities of Daily Living, Lifting, Other. Each column contains a list of activities with checkboxes.

Do you feel that in your condition you may need the assistance with some of these or other tasks? \_ Yes \_ No

If Yes, would you like for us to help you find out where these services are available in your local community? \_ Yes \_ No

What do you hope to achieve with physical therapy? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_