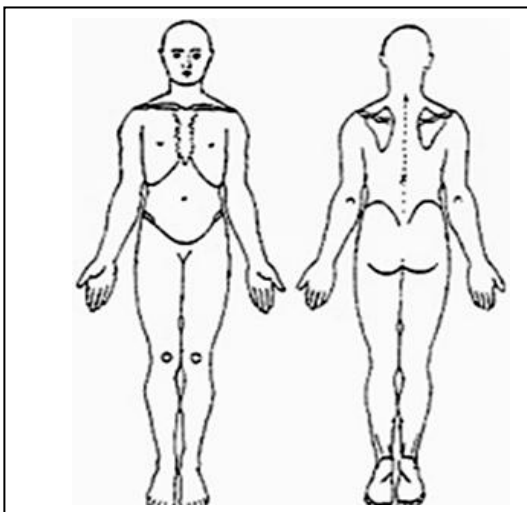


PHYSICAL THERAPY PLUS MEDICAL QUESTIONNAIRE

Legal Name: _____ Date: _____ DOB: _____ Age _____
 Occupation: _____ Employer: _____ Hrs./Wk _____
 What problem or diagnosis brings you here today? _____
 Side of Injury: R ___ Left ___ 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: 1 2 3 4 5 6 7 8 9 10

Pain with activity: 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? ___ Yes ___ No

If yes, how many times? _____

What eases your symptoms? _____

What aggravates your symptoms? _____

Are you symptoms getting ___ Better ___ Worse ___ Same

Is your pain worse in the ___ AM ___ PM ___ Mid-day

Are you currently working? ___ Y ___ N If yes, ___ Light Duty ___ Normal Duty

Is this a motor vehicle claim? ___ Y ___ N

What activities at home, work or recreation 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 activities: _____

MEDICAL HISTORY - Check all that apply

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> MRS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker/Nitroglycerin |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Poor Circulation/Raynaud's |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bowel or Bladder Problems | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Menopause | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Carpel Tunnel Syndrome | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> TB |
| <input type="checkbox"/> Chest/Abdominal Surgery | <input type="checkbox"/> Fractures | <input type="checkbox"/> Major Spinal Injury | <input type="checkbox"/> Traumatic Injury/MVA |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> 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? _____

List current medications: _____

List current List current allergies: _____

List all surgeries: _____

Signature _____

Date _____