Patient Medical History Questionnaire

Patient Name: _____ Date:_____

Date of Birth: _____ **Age:** _____ **Height:** _____ **Bodyweight:** _____

Indicate any of the following conditions that apply to you:

___ Allergies
___ Amputation
___ Anemia
___ Angina
___ Anxiety
___ Asthma
___ Ataxia
___ Bell's Palsy
___ Blood Disorder
___ Clot/ Emboli
___ Bowel /Bladder
___ Bronchitis
___ Cancer
___ Carpal Tunnel
___ Cellulitis
___ Cerebral Palsy
___ Concussion
___ COPD
___ Depression
___ Diabetes, Type 1
___ Diabetes, Type 2
___ Dizziness or Faintness
___ Drink Alcohol
___ Emphysema
___ Energy Loss
___ Epilepsy / Seizures
___ Headache, severe
___ Heart Attack/ Disease
___ High Blood Pressure
___ Kidney Disease
___ Lipedema
___ Low Blood Pressure
___ Lymphedema
___ Mastectomy
___ Multiple Sclerosis
___ Neurological Issues
___ Osteo arthritis
___ Osteoporosis
___ Oxygen Dependency
___ Pacemaker
___ Parkinson's Disease
___ Pneumonia
___ Rheumatoid Arthritis
___ Sciatica
___ Shortness of Breath
___ Skin Disorders
___ Sleep Apnea
___ Sleeping Problems
___ Spinal Stenosis
___ Stroke/ TIA
___ Thyroid Disorder
___ Torticollis
___ Urinary Incontinence
___ Varicose Veins
___ Vasculitis
___ Vertigo or Balance
___ Women's Health
___ Pregnant
___ Other

___ I live alone
___ I am a caregiver
___ I use a cane
___ I've had in home PT/OT
___ I use a wheelchair
___ I use a walker

___ Location of Arthritis _____

___ Numbness/ Tingling _____

___ Falls in past year Number: _____ Injuries due to falls: _____

___ Hospitalizations / Surgeries _____

___ Joint Replacements or Surgical Implants _____

Have you often been bothered by feeling down, depressed, or hopeless? Y / N

Have you been bothered by having little interest or pleasure in doing things? Y / N

Do you currently use tobacco? Y / N ___ smoke ____ snuff ____ chew.
Have you been counselled in tobacco cessation? Y / N

Current medications: _____

_____

Are you allergic to medications, metals, latex, or other substances? Y / N_____

What is your exercise experience? _____

_____

How often do you exercise weekly? _____

Patient/ Guardian Signature _____

Patient Medical History Questionnaire

Patient Name: _____ Date:_____

Describe your current condition, problem, or need for physical therapy: _____

_____

Date of Onset of symptoms or pain? _____

List any treatment of this condition to date: _____

_____

Diagnostic Tests and Results: _____

Pain is described by:
___ Aching ___Burning ___ Constant ___Cramping ___Deep ___Dull ___ Heavy ___ Numb
___ Stabbing ___ Throbbing ___ Variable ___ Weak ___ Pins/ Needles

Pain is aggravated by:
___Carrying items ___ Lifting heavy weight ___Lifting anything ___ Bending
___ Climbing Stairs ___ Dressing/Grooming ___ Getting out of bed ___ Cooking ___ Reaching Back
___ Raising arms overhead ___ Looking Up ___ Lying Flat ___ Pulling ___Twisting
___ Walking ___ Sitting

Pain is eased by: ___ Ice ___ Heat ___ Medication ___ Lying Flat ___ Stretching ___ Exercise ___ Rest

Does your routine or work aggravate your injury/ condition?
___ No ___ Once Weekly ___ Biweekly ___ Daily

___ Unable to participate in normal routine

Does your injury/ condition impact your ability to do your job?
___ Retired ___ Prevents me from working ___ I can only work part-time ___I work with minor difficulty
___ I work with great difficulty ____Does not impact my ability to work

Does your injury/ condition impact your ability to attend school?
___ N/A ___ Prevents me from attending school ___ Attends school, large impact
___ Attends school, minor impact ___ School is normal, can't participate in sports ____ No restrictions

What is/are your goal(s) to accomplish with physical therapy?

_____

_____

Patient/ Guardian Signature _____

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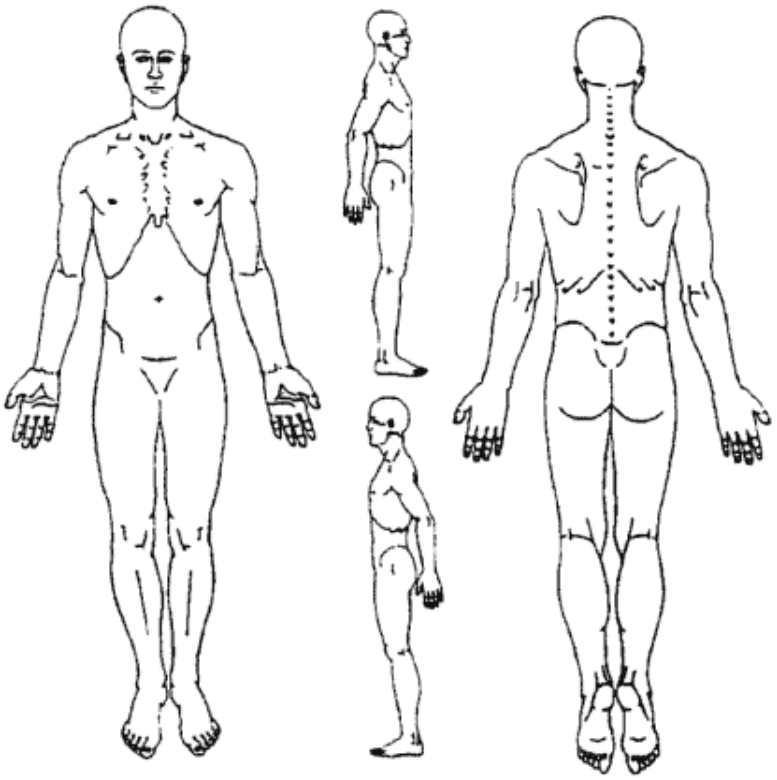
Pain Diagram and Rating

Please choose the symbol(s) in the box that describes the type of pain or sensation you are currently experiencing and draw it on the diagram where you experience it.



A=Achy
B=Burning
D=Dull
N=Numbness
S=Sharp
T=Tingling

Please mark the **severity of pain** (Visual Analog Pain Severity Scale):

- **Current** pain: 0 1 2 3 4 5 6 7 8 9 10
- **Worst** pain in last week: 0 1 2 3 4 5 6 7 8 9 10
- **Least** pain in last week: 0 1 2 3 4 5 6 7 8 9 10

Patient/ Guardian Signature _____