



Patient Questionnaire / Medical History Form

Under Medicare and the State practice acts, we are required to obtain a complete medical history on all patients.
This information is protected under HIPAA laws. Please answer all questions to the best of your ability.

Last Name: _____ First Name: _____ MI: _____ Date: _____

DOB: _____ Age: _____ Sex: ☐ M ☐ F Hand Dominance: ☐ R ☐ L Height: _____ Weight: _____

How did you hear about us? _____

Primary Care Doctor: _____ Referring Doctor: _____

If accident, circle place where occurred: ☐ Home ☐ Auto ☐ Work ☐ Sports ☐ Other: _____ Next Doctor's Visit: _____

Occupation: _____ Work involved? _____ Current Work Status: _____

Do you have any lifting restrictions? ☐ Y ☐ N Do you live alone? ☐ Y ☐ N Are there stairs where you live? ☐ Y ☐ N

What is the reason for your visit today? _____

Briefly describe how your problem began: _____

What goals would you like to achieve through therapy? _____

Date of onset/injury: _____ Date of surgery: _____ Type of Surgery: _____

Prior or ongoing treatments for your current chief complaint include: (Check all that apply) ☐ No treatment received yet

☐ Physical Therapy	☐ Chiropractic Care	☐ Pain Management	☐ Mechanical Traction
☐ Massage Therapy	☐ Injections	☐ Aquatic Therapy	☐ Brace / Tape
☐ Surgical Intervention	☐ Personal Training	☐ Athletic Training	☐ Other: _____

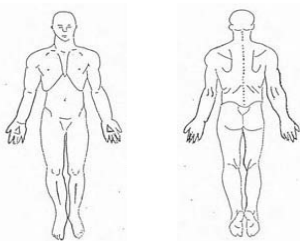
Have any diagnostic tests been performed for this problem? (Check all that apply)

☐ X-rays ☐ Bone Scan ☐ Doppler Ultrasound ☐ MRI ☐ EMG ☐ CT Scan ☐ Blood Work ☐ Other: _____

Please list body part tested and date tested: _____

Have you had similar symptoms in the past? ☐ Y ☐ N Have you received Home Health PT prior to coming here? ☐ Y ☐ N

Please circle where you hurt:



Where did your pain start? _____

Since it started, the pain is: ☐ getting worse ☐ improving ☐ the same

Describe pain: ☐ sharp ☐ dull ☐ aching ☐ sore ☐ throbbing ☐ cramping
☐ burning ☐ shooting ☐ stabbing ☐ squeezing ☐ constant
☐ intermittent ☐ Other: _____

What makes it worse? _____

What makes it better? _____

Does time of day affect pain? _____

Does pain wake you from sleep? _____

Please rate your pain on 0-10 scale (0 is no pain; 10 is the worst you can imagine):

Least:

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

 Worst:

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

 Present:

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Do you have any tingling, numbness, or loss of sensation? ☐ Y ☐ N If so, where? _____

Do you have any weakness? ☐ Y ☐ N If so, for how long? _____

Do you have any swelling? ☐ Y ☐ N If so, where? _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Give answers as 0 to 3, using this scale:

0=Not at all; 1=Several days; 2=More than half the days; 3=Nearly every day

1. Little interest or pleasure in doing things
☐ 0 ☐ 1 ☐ 2 ☐ 3
2. Feeling down, depressed, or hopeless
☐ 0 ☐ 1 ☐ 2 ☐ 3

Please complete this section if you are 65 years of age or older:

Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals? ☐ Y ☐ N

Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care or from being with people you wanted to be with? ☐ Y ☐ N

Have you been upset because someone talked to you in a way that made you feel shamed or threatened? ☐ Y ☐ N

Has anyone tried to force you to sign papers or to use your money against your will? ☐ Y ☐ N

Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically? ☐ Y ☐ N

Please choose Yes or No if you have had any of the following conditions:

High Blood Pressure ☐ Y ☐ N

High Cholesterol ☐ Y ☐ N

Bowel/Bladder Dysfunction ☐ Y ☐ N

Acid Reflux/Ulcers ☐ Y ☐ N

Thyroid Disorder ☐ Y ☐ N

Bleeding Disorder ☐ Y ☐ N

HIV/AIDS ☐ Y ☐ N

Mental Disorder type: _____

Seizures/Epilepsy ☐ Y ☐ N

Lyme Disease ☐ Y ☐ N

Congestive Heart Failure ☐ Y ☐ N

Currently Pregnant-#wks: _____

Diabetes ☐ Y ☐ N

Heart Attack ☐ Y ☐ N

Cardiac Bypass ☐ Y ☐ N

Cardiac Stents ☐ Y ☐ N

Chest Pain ☐ Y ☐ N

Hepatitis ☐ Y ☐ N

Parkinson's Disease ☐ Y ☐ N

COPD/Asthma ☐ Y ☐ N

Emphysema ☐ Y ☐ N

Lupus ☐ Y ☐ N

Kidney Disease ☐ Y ☐ N

Stroke ☐ Y ☐ N

OTHER: _____

Osteoarthritis ☐ Y ☐ N

Rheumatoid Arthritis ☐ Y ☐ N

Osteoporosis or -penia ☐ Y ☐ N

Scoliosis ☐ Y ☐ N

Headaches/Migraines ☐ Y ☐ N

Dizziness or Fainting ☐ Y ☐ N

Dementia/Alzheimer's ☐ Y ☐ N

Cancer type: _____

Recent Infection ☐ Y ☐ N

Multiple Sclerosis ☐ Y ☐ N

Fibromyalgia ☐ Y ☐ N

Allergies-list: _____

Best answer over the past year:

Do you use tobacco? ☐ Y ☐ N # Packs/day: _____

Do you wear glasses or contacts? ☐ Y ☐ N

Do you wear dentures or hearing aide? ☐ Y ☐ N

Do you have a pacemaker? ☐ Y ☐ N

Do you have metal implants? ☐ Y ☐ N

Do you use a cane or crutches? ☐ Y ☐ N

Do you use walker or wheelchair? ☐ Y ☐ N

Have you fallen two or more times? ☐ Y ☐ N

Have you sustained an injury as a result of these falls? ☐ Y ☐ N

How would you rate your overall Health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Please list previous surgeries in the last 5 years with dates or any disorders not listed above:

Please list all medications/supplements you are taking, including dosage and frequency:

Who should we contact in case of emergency?

Name: _____ Relation: _____ Phone: _____

To the best of my ability, I have given and included all pertinent information:

Patient/Guardian Signature: _____ Date: _____

Medical history reviewed by physical therapist and used in determining the Plan of Care.

Therapist Signature: _____ Date: _____