Medical Questionnaire

Name: _____ DOB: _____ Today's Date: _____

The following information is important to your therapist in developing an appropriate plan of care and identifying any issues that may impact the achievement of any of the goals developed for your physical therapy plan of care.

R- handed: ____ L-handed: ____ Ht.:_____ Wt.: _____

Have you ever been a patient here before? Yes_____ No _____; If yes, for the ____same or ____different problem?

Please indicate for which body region you are seeking treatment:
__Neck __Mid Back __Low Back __Shoulder __Elbow __Hand/wrist __Hip __Knee __Ankle/foot __Other

Have you ever had similar symptoms in the past? Yes ____ No ____ If yes, when?

Have you recently had the following tests? Yes ____ No____ If yes, check all that apply/when was test performed:
_____x-rays _____Bone Scan _____Myelogram _____EKG
_____CT Scan _____EMG _____Stress Test _____Echocardiogram
_____MRI _____Blood Tests _____Pulmonary Function Test _____Other _____

Have you had a surgical intervention for this problem? Yes ____ No ____ If yes, specify: _____
Date of surgery: _____

Have you had any changes in your bowel, bladder or sexual function as a result of your symptoms? Yes __ No __
Describe _____

Have you <u>previously</u> seen any other health care provider for this problem? ____ Yes ____No
If yes, check all that apply/when:
_____Physician _____Osteopath _____Podiatrist _____ Dentist
_____Physical Therapist _____Chiropractor _____Other _____

Are you currently seeing any other health care provider for this condition? ____Yes ____No; If Yes, please list:
_____

Have you been discharged from the hospital, a skilled nursing facility, or Home Health Agency in the past 30 days related to this condition? Yes ___ No ____ If yes, please describe: _____

Please <u>check all</u> those treatments listed below that have been tried in the past:
___Physical Therapy ___Chiropractic ___Acupuncture ___Braces ___Collars ___Tens Unit ___Injections
___Medications ___None ___Other (please describe):_____

Medication Record:

Please list all current medications, with dosages (Include prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements).

☐If you already have a list (including dosage amounts) please check here and provide a copy of the list to your therapist at the time of your evaluation _____ (Patient initials)

Medication	Dosage	Reason for Taking

Use the additional space on the last sheet if more space is needed

Medical Questionnaire

Patient's Name: _____ Date: _____

Have you ever had an allergic reaction to: ☐ Lotion ☐ Perfume ☐ Gel ☐ Latex ☐ Adhesives?

Are you pregnant? ☐ No ☐ Yes

Do you have a pacemaker? ☐ No ☐ Yes

Do you have or have ever had any of the following?

☐ No ☐ Yes Cancer (if so, what type? _____)
☐ No ☐ Yes Chemotherapy or Radiation
☐ No ☐ Yes High blood pressure
☐ No ☐ Yes Angina or Coronary Heart Disease
☐ No ☐ Yes Heart Attack
☐ No ☐ Yes Heart Surgery
☐ No ☐ Yes Chemical dependency (i.e. alcoholism)
☐ No ☐ Yes Rheumatoid arthritis
☐ No ☐ Yes Other arthritic conditions
☐ No ☐ Yes Stroke/TIA
☐ No ☐ Yes Other Neurological Disorder (Specify: _____)
☐ No ☐ Yes Kidney Disease
☐ No ☐ Yes Epilepsy/Seizures
☐ No ☐ Yes Osteopenia/Osteoporosis
☐ No ☐ Yes Blood Clot
☐ No ☐ Yes Joint Replacement or Revision (Specify: _____)

☐ No ☐ Yes Depression
☐ No ☐ Yes Diabetes
☐ No ☐ Yes Circulation problems
☐ No ☐ Yes Asthma
☐ No ☐ Yes Emphysema/Bronchitis
☐ No ☐ Yes Thyroid problems
☐ No ☐ Yes Multiple Sclerosis
☐ No ☐ Yes HIV
☐ No ☐ Yes Hepatitis
☐ No ☐ Yes Tuberculosis
☐ No ☐ Yes Hernia
☐ No ☐ Yes Anemia
☐ No ☐ Yes Incontinence
☐ No ☐ Yes Hearing Loss
☐ No ☐ Yes Vision Loss
☐ No ☐ Yes Other _____

Have you recently noted:

☐ No ☐ Yes Weight loss/gain
☐ No ☐ Yes Dizziness/lightheadedness
☐ No ☐ Yes Severe or frequent headaches
☐ No ☐ Yes Numbness or tingling
☐ No ☐ Yes Shortness of breath
☐ No ☐ Yes Chest pain
☐ No ☐ Yes Swollen joints

☐ No ☐ Yes Nausea/vomiting
☐ No ☐ Yes Fatigue
☐ No ☐ Yes Weakness
☐ No ☐ Yes Fever/chills/sweats
☐ No ☐ Yes Bowel or Bladder leakage
☐ No ☐ Yes Difficulty sleeping

During the past month have you been feeling down, depressed or hopeless? ☐ No ☐ Yes
During the past month have you been bothered by having little interest or pleasure in doing things? ☐ No ☐ Yes
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ☐ No ☐ Yes
How many packs of cigarettes do you smoke a day? _____
How many days per week do you drink alcohol? _____

Where do you currently live (or intend to live) at the conclusion of your episode of therapy?
__ Private Home __Private Apartment __Rented Room __Group Home __Assisted Living __Skilled Facility __Other

Who do you live with (or intend to live with) at the conclusion of your episode of therapy?
__Live Alone __Spouse/Significant Other __Child/Children __Other Relative __ Personal Care Attendant __Other

Job Description/Social Activities: (physical tasks, amount of sitting, lifting, computer work etc.):

_____

Have you missed work due to your condition/injury/problem? ☐ No ☐ Yes

If Yes: Last date worked due to this injury? _____
Date returned to work after this injury? _____

At the present time, would you say your health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Patient Signature: _____ Date: _____

Evaluating Physical Therapist Signature: _____ Date: _____

☐ Margaret Conze, PT 20498
☐ Abigail Sherman, DPT 23182
☐ Christine Grossnickel, PT 18778
☐ Tammy McEnerney, PT 21118
☐ Parastoo Satarzadeh Moghaddam, DPT 22297
☐ Monika Twardzik-Roberts, MPT 19778
☐ Amy Pannell, DPT 22998
☐ Gary Lin, MPT 20386
☐ Eileen Blahut, MPT 19471
☐ Martin Clarke, MPT 20822
☐ Michelle Zygielbaum, PT