Medical History and Physical Questionnaire

The following information will be used to establish a Physical Therapy treatment plan to restore your functional ability. All information is considered confidential and will only be released with your written authorization.

Name: _____Date:_____

Referring Physicians Name: _____

Briefly describe chief complaint/symptoms: _____

Onset/Date of Injury: _____ How did your symptoms start? _____
_____

Surgery for present injury? Y___ N___ When? _____

Test (MRI, X-ray etc.) _____ When? _____

Have you previously received any type of treatment for this condition? If so When?
_____

Other injuries (date & treatment within the last 7 years) _____
_____

Medications (please list) _____

Check all that apply for any condition you have currently or have experienced in the past:

☐ Allergies	☐ Ear Problems	☐ High Blood Pressure	☐ Pacemaker
☐ Balance	☐ Eye Problems	☐ HIV/Aids	☐ Pregnancy
☐ Circulatory Problems	☐ Heart Disease	☐ Lung Disease	☐ Seizures
☐ Diabetes	☐ Headaches	☐ Metal Plates/Pins	☐ Skin Disorder
☐ Dizzy Spells	☐ Hernia	☐ Neurological Disorder	

Check all that apply of what you are currently unable to do as a result of your condition:

☐ Bend	☐ Grip with hand	☐ Prolonged Standing	☐ Stairs
☐ Dress	☐ House hold chores	☐ Sit	☐ Stand up
☐ Drive	☐ Lift/Carry	☐ Sleep	☐ Walk / Run
☐ Groom	☐ Overhead lift / reach	☐ Squat	☐ Work

Other (please explain): _____

SUBJECTIVE EVALUATION

This questionnaire is designed to help your therapist determine the location, nature, and factors that affect your pain or dysfunction. Please fill out as able, and make any additional comments about your status. Your therapist will discuss your comments in more detail during your evaluation.

Occupation _____ Hours / week _____

Physical Activities in Occupation (e.g. sitting, bending, lifting, computer etc.) _____
_____

Sports, Hobbies or Physical Activities? Please Specify: _____
_____

Pain Description

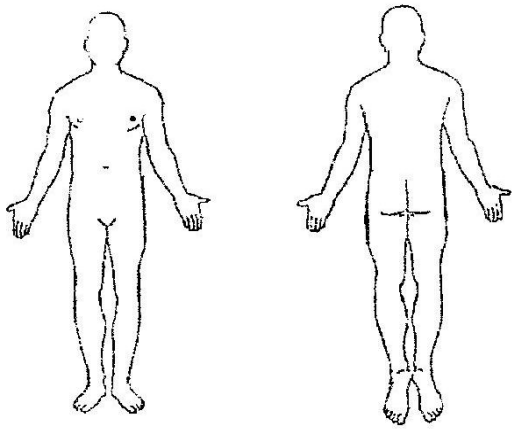
___ Traumatic (caused by injury)
___ Non-Traumatic (no real cause)

How is your pain changing?
___ Getting better
___ Not changing
___ Getting worse

What is the nature of your pain?

___ Constant	___ Sharp
___ Occasional	___ dull ache
___ numbness	___ throbbing
___ tingling	___ burning

Areas of pain abnormal sensation
Shade in where appropriate



During the past 4 weeks:

Indicate the average intensity of your pain

None										Severe
0	1	2	3	4	5	6	7	8	9	10

History of Pain:

Have you had any previous history of similar problems? ( ) Yes ( ) No When? _____

What helped the most to relieve the previous attacks? _____

Do you have pain at night Yes____ No____

What makes your pain worse? _____

What helps your pain? _____

How much has pain/symptoms interfered with your normal work (including housework)
1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

How much has your pain/symptoms interfered with your social activities?
1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

In general would you say your health right now is….
1. Excellent 2. Very good 3. Good 4. Fair 5. Poor