restorations physical therapy

Medical History Questionnaire

Patient Name: ____ Date: ______________

Chief Complaints and Onset Date: ____

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Please mark your pain on the body shown below. Use the following markings:

√√√ = Sharp Pain   OOO = Dull Pain   /// = Numbness   +++ = Tingling   Draw arrows (↓) for radiating pain

Please rate your pain (0 = No pain; 10 = Severe pain that would send you to the hospital):

CURRENT PAIN: 0 1 2 3 4 5 6 7 8 9 10

WORST PAIN IN PAST 24 HOURS: 0 1 2 3 4 5 6 7 8 9 10

BEST PAIN IN PAST 24 HOURS: 0 1 2 3 4 5 6 7 8 9 10

List any diagnostic tests (X-rays, MRIs, etc.) & the results: ______________________________

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____

Do you smoke or use tobacco products? Y N

Do you have any allergies? Y N Please list: ______________________________________

MEDICAL HISTORY QUESTIONNAIRE - CONTINUED

Patient Name: ____

Do you have or have you ever had any of the following? Please mark all that apply.

☐ Diabetes (type: ________)
☐ Heart Problems/Disease
☐ Pacemaker
☐ Stroke (date: __________)
☐ Arthritis
☐ Cancer
(type: _______________
date: ______________)
☐ Thyroid Disease
☐ High Blood Pressure (HTN)
☐ Chest Pain/Tightness
☐ MI/Heart Attack
☐ Shortness of Breath

☐ Asthma
☐ Bowel/Bladder Changes
☐ Pain/Burning w/Urination
☐ Neuropathy
☐ Epilepsy/Seizure
☐ Balance Problems
☐ Tremors/Shaking
☐ Dizziness/Falls
☐ Poor Circulation
☐ Recent Weight Loss/Gain
☐ Freq. Headaches/Migraines
☐ Blurred Vision
☐ Prior Fractures

☐ Osteoporosis/Osteopenia
☐ Gout
☐ Bone/Joint Problems
☐ Blood Transfusion
☐ HIV/AIDS
☐ Hepatitis
☐ Parkinson's
☐ Multiple Sclerosis
☐ Alzheimer's/Dementia
☐ Psychiatric Problems
☐ Latex Allergy

Are there any conditions or diseases not listed that you have or have had? Please list. ________________________

Are you currently being seen by a physician or other medical professional for the items marked? Y N

Have you had any falls in the past year? Y N If yes, how many? ____

List any & all medications including supplements (include dosage, frequency, & route of administration):

☐ Not currently taking any medications

Medication Name	Dosage	Frequency	Route of Admin

(continue on back if necessary)

List all surgeries, significant injuries & illnesses: ____

Have you had physical therapy before? Y N
If yes, list reasons and when you had PT: ____

Female Patients: Are you pregnant or breastfeeding? Y N
If pregnant, what is your expected delivery date? __________________

To the best of my knowledge this information is correct and accurate.

Patient Signature Date