Medical History Questionnaire

Patient Name: _____ Date: _____

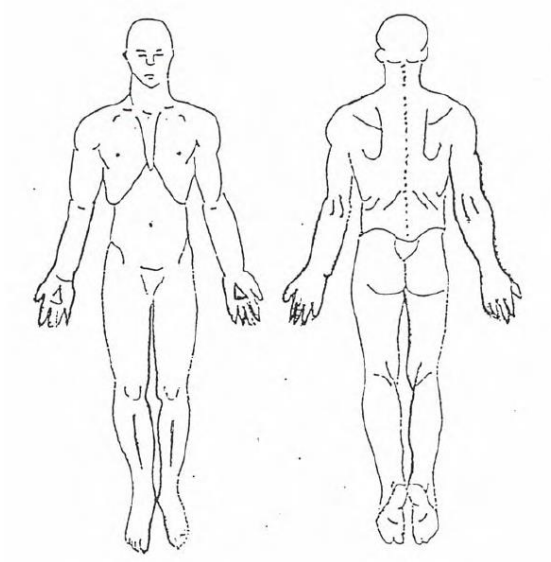
Chief Complaints and Onset Date: _____

_____

_____

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

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

Referring physician: _____ PCP: _____

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

_____

_____

Do you smoke or use tobacco products? Y N

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

MEDICAL HISTORY QUESTIONNAIRE - CONTINUED

Patient Name: _____

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

Do you have an active diagnosis of depression and/or bipolar disorder by another medical professional? Y N

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

☐ Not currently taking any medications

Medication Name	Dosage	Frequency	Route of Admin (ex: oral)

(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? _____

Please list at least one emergency contact:

Name:_____ Phone:_____

Name:_____ Phone:_____

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

_____

Patient Signature (Parent if patient is a minor) Date