

Medical Questionnaire

Name: Date: Height: Weight:

What are your symptoms and when did they start:

Describe how your condition or injury occurred:  Work  Sports Injury  Auto Accident

Other

**Shade area of Pain** Please rate your pain on the scale below of 0 to 10:

( 0 = no pain; 10 = worst pain imaginable/emergency room pain)

Pain at rest: Pain with activity:



Does your pain wake you at night:  Yes  No

What eases your symptoms?

What aggravates your symptoms?

Have you had any previous treatment?

Have you had any of the following: X-rays  MRI  CT Scan

Other:

Side of injury: Right Left

Are you currently working:  No  Yes Full-time  Part-time  Restricted

What activities at home, work or recreational are you unable to perform:

What goals do you hope to accomplish with Physical Therapy:

How did you hear about us:

Medical History (check all that apply)

Cancer  Breathing Difficulties Diabetes Pacemaker

High Blood Pressure  Joint Replacement Heart Disease History of seizures

Recent Surgery  Bone & Joint disorders Are you pregnant  Yes  No

Other Past Medical History or surgeries:

Medications:

Signature: Date: