

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: