Patient Medical History and Intake Questionnaire

Patient Name:_____ Age: _____ Sex : F____ M ____

What is your main complaint and in what area is it located?_____

_____

Occupation: _____

Are you presently working? Yes _____ No _____ If no—Last Day Worked: _____

Have you ever had these symptoms before? Yes ____ No _____ If so, When? _____

Have you had physical therapy, occupational therapy or chiropractic care for this injury before? Yes_____ No _____

Which one and when? _____

Check all of those which apply to your current condition:

____ Work Related Injury ____Sports Injury ____Fall

____ Motor Vehicle Accident ____Aggravation of Pre-Existing Injury ____Causes Unknown

____ Injury Recurrence ____Lifting Injury

____Other: _____

What have you been doing to decrease your pain? _____

On a scale from 0 (no pain) to 10 (very severe pain), what is your pain level? _____

Are your symptoms getting worse/ better/ the same/ since your injury? _____

Are you currently taking any medications? (Please list) _____

_____

Are you allergic to any medications? (If yes, please list) _____

_____

Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
Diabetes	____	____	Cancer	_____	____	Metal Implants	____	____
Chest Pain	____	____	Asthma	_____	____	Dizziness	____	____
Heart Disease	____	____	Arthritis	_____	____	Fractures	____	____
Pacemaker	____	____	Aids/HIV	_____	____	Skin Allergies	____	____
Headaches	____	____	Allergies to Heat	___	____	Nausea/Vomiting	___	____
Kidney Problems	____	____	Allergies to Cold	___	____	Ear Ringing	____	____
Are You Pregnant	____	____	Seizures	_____	____	Hypoglycemia	____	____
Bladder Problems	____	____	Respiratory Problems	_____	____	High Blood Pressure	____	____

If you answered yes to any of the above, please explain and give an approximate date of occurrence: _____

_____

Please **circle** tests you have had performed:

None *X Rays* *MRI* *CT Scan* *Bone Scan* *Other (Explain)*_____

Check any of the following activities which you have difficulty with due to your injury:

____Housekeeping ____Lifting ____Driving ____Shopping ____Reaching

____Dressing ____Cooking ____Climbing Stairs ____Child Care ____Bending

____Yard Work ____Sit to Stand

List all of your surgeries: _____

_____

Is there any other information about your present health that we should know about? _____

_____ _____ _____

Patient Signature Date PT/OT Initials