Medical Questionnaire

Patient: _____ Age: _____

I certify that to the best of my knowledge the information below is accurate. I understand that it is my responsibility to inform my therapist immediately if there is any significant change in this information or my condition. I am aware that my diagnosis and treatment plan will be discussed and that I have the right to refuse any treatment offered.

Past Medical History (Please circle all that apply):

Allergies/Asthma Cancer Dizziness/Vertigo Diabetes Fibromyalgia

Heart Disease High Blood Pressure Pregnancy Hearing Loss Incontinence

Osteoarthritis Osteoporosis Surgeries Neuropathy Numbness/tingling

Reflux/GERD Ulcers Stroke Rheumatoid Arthritis Skin Disease Auto Immune

Are you a smoker: Yes No Are you Pregnant: Yes No

Do you take blood thinners: Yes No

Are you taking a Statin drug: Yes No Are you taking High Blood Pressure Medication: Yes NO

Are you Right of Left Handed: _____

Any past surgeries? _____

_____

_____

Any past injuries?

_____

_____

_____

Any falls within the past year? If yes, how many?

_____

What do you do for exercise? Hobbies? Activity?

_____

_____

_____

Current Issue(s)

Describe current issue(s)

_____

_____

_____

Cause of Injury: _____Date of Surgery: _____

Pain Rating now: _____ out of 10 (0 out of 10 = no pain 10 out of 10 is the worst pain imaginable)
Pain Rating at worst: _____ Pain Rating at best: _____

Other symptoms: (circle all that apply)

Changes in bowel or bladder Change in Appetite Depression Difficulty Swallowing
Fever/Chills Headache Night Sweats Numbness Nausea/Vomiting Poor Balance
Shortness of Breath Pins and Needles/Tingling Difficulty Sleeping Dizziness

Please indicate the number which describes your current level of function: _____
(unable to do anything = 0 and able to do everything = 10)

What makes symptoms worse: _____

What makes symptoms better: _____

Have you had an X-ray, MRI, EMG or other scan done? Yes or No
If yes, which _____ and when _____

Have you ever had a cortisone injection or taken steroid pills? Yes or No
If yes, which _____ and when _____

What are your physical goals?

_____

_____

_____

Signature of Patient or Responsible Person: _____
Date: _____