

**PATIENT MEDICAL HISTORY**

**PLEASE MARK THE FOLLOWING IF YOU HAVE HAD:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Alcohol abuse problems | <input type="checkbox"/> Epilepsy/Seizures         | <input type="checkbox"/> Kidney Disease   |
| <input type="checkbox"/> Allergies              | <input type="checkbox"/> Fractures (broken bones)  | <input type="checkbox"/> Lung disease     |
| <input type="checkbox"/> Angina                 | <input type="checkbox"/> Gastrointestinal problems | <input type="checkbox"/> Muscle strains   |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Gout                      | <input type="checkbox"/> Neck Injuries    |
| <input type="checkbox"/> Back injuries          | <input type="checkbox"/> Heart Attacks             | <input type="checkbox"/> Nervous Problems |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> Osteoporosis     |
| <input type="checkbox"/> Circulatory problems   | <input type="checkbox"/> Heart Surgery             | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> High blood pressure       | <input type="checkbox"/> Tumors           |
| <input type="checkbox"/> Dislocation (joints)   | <input type="checkbox"/> Jaw injuries/TMJ          | <input type="checkbox"/> Whiplash         |
| <input type="checkbox"/> Emotional Problems     | <input type="checkbox"/> Joint strains             |   |

**CHECK THE FOLLOWING BOXES IF YOU HAVE RECENTLY EXPERIENCED:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Balance problems                          | <input type="checkbox"/> Falls                          | <input type="checkbox"/> Tingling, numbness or loss of feeling |
| <input type="checkbox"/> Blurred/double vision                     | <input type="checkbox"/> Headaches                      | <input type="checkbox"/> Tremors                               |
| <input type="checkbox"/> Change in bowel / bladder habits          | <input type="checkbox"/> Hoarseness                     | <input type="checkbox"/> Unexplained weight loss               |
| <input type="checkbox"/> Constant Pain unrelieved by rest/movement | <input type="checkbox"/> Muscular pain at rest          | <input type="checkbox"/> Unusual fatigue                       |
| <input type="checkbox"/> Difficulty sleeping                       | <input type="checkbox"/> Muscular pain with exertion    | <input type="checkbox"/> Unusual skin coloration               |
| <input type="checkbox"/> Dizziness                                 | <input type="checkbox"/> Pain with coughing or sneezing | <input type="checkbox"/> Unusual weakness                      |
|  | <input type="checkbox"/> Shortness of breath            |  |

**PLEASE LIST ANY MAJOR SURGERIES AND HOSPITALIZATIONS**

\_\_\_\_\_ DATE: \_\_\_\_\_  
\_\_\_\_\_ DATE: \_\_\_\_\_

**DO YOU SMOKE?**  Yes  No If Yes, How many pack per day? \_\_\_\_\_ **ARE YOU PREGNANT?**  Yes  No

**ARE YOU ALLERGIC TO ANY MEDICATION?**  Yes  No IF YES, PLEASE LIST MEDICATIONS BELOW:

\_\_\_\_\_  
\_\_\_\_\_

**PLEASE LIST ALL MEDICATIONS YOU ARE PRESENTLY TAKING:**

\_\_\_\_\_

**PLEASE MARK THE FOLLOWING IF ANY OF THESE DIAGNOSTIC TESTS HAVE BEEN PERFORMED?**

- |                                  |             |                |
|----------------------------------|-------------|----------------|
| <input type="checkbox"/> X-RAYS  | DATE: _____ | RESULTS: _____ |
| <input type="checkbox"/> MRI     | DATE: _____ | RESULTS: _____ |
| <input type="checkbox"/> EMG/NCV | DATE: _____ | RESULTS: _____ |

**IS YOUR PROBLEM DUE TO:**

- Injury  Work Related  Motor Vehicle Accident  Other Date of Injury: \_\_\_\_\_

**PLEASE DESCRIBE YOUR PROBLEM?**

\_\_\_\_\_

**WHAT ARE YOUR GOALS FOR PHYSICAL THERAPY?**

\_\_\_\_\_

**PLEASE CHECK THE FOLLOWING WHICH BEST DESCRIBE YOUR PAIN**

- |                                     |   |   |                                     |
|-------------------------------------|---|---|-------------------------------------|
| <input type="checkbox"/> CONSTANT   | <input type="checkbox"/> DULL/ACHY PAIN | <input type="checkbox"/> STIFFNESS        | <input type="checkbox"/> OCCASIONAL |
| <input type="checkbox"/> INCREASING | <input type="checkbox"/> INTERMITTENT   | <input type="checkbox"/> SHARP PAIN       | <input type="checkbox"/> STATIC     |
| <input type="checkbox"/> NIGHT PAIN | <input type="checkbox"/> DECREASING     | <input type="checkbox"/> PAIN UPON WAKING |                                     |

PAIN IS AGGRAVATED BY: \_\_\_\_\_

PAIN IS EASED BY: \_\_\_\_\_

HAVE YOU BEEN TREATED BY A **Physical Therapist/Chiropractor?**  Yes  No IF YES, WHEN \_\_\_\_\_

WHAT WERE YOU TREATED FOR? \_\_\_\_\_

**I, THE UNDERSIGNED, STATE THAT I HAVE ANSWERED THIS QUESTIONNAIRE TO THE BEST OF MY KNOWLEDGE.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_