ESSENTIAL PHYSICAL THERAPY AND WELLNESS

Medical History Questionnaire

Name: _____ Date of Birth: _____

Address:_____

STREET CITY STATE ZIP

Check Preferred Contact

□ Home Phone: _____

□ Cell Phone: _____

□ Email: _____

Emergency Contact:_____ Phone: _____

Referring Practitioner: _____ Phone: _____

Primary Care Physician: _____

Body part/area to be treated: _____

Occupation/Sport/Recreation: _____

Symptom Onset Date: _____

How did you hear about Essential Physical Therapy :_____ Date Completed: _____

Do you have a history of any of the following?

High Blood Pressure	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Hepatitis/HIV	☐ Yes ☐ No
Angina/Chest Pain	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No	Headaches	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Depression	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Double Vision	☐ Yes ☐ No	Ringing in ears	☐ Yes ☐ No
Kidney disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No
Autoimmune disease	☐ Yes ☐ No	Artificial joints	☐ Yes ☐ No	Blood clots	☐ Yes ☐ No
Circulation problems	☐ Yes ☐ No	Thyroid problems	☐ Yes ☐ No	Food sensitivities	☐ Yes ☐ No

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In the past 3 months have you experienced any of the following?

Change in your health	☐ Yes ☐ No	Memory change/fog	☐ Yes ☐ No	Unexplained weight change	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No	Fatigue/weakness	☐ Yes ☐ No	Change in appetite	☐ Yes ☐ No
Dizziness	☐ Yes ☐ No	Fainting	☐ Yes ☐ No	Upper respiratory infection	☐ Yes ☐ No
Fever/Chills/Sweats	☐ Yes ☐ No	Difficulty swallowing	☐ Yes ☐ No	Change in bowel/bladder	☐ Yes ☐ No
Numbness/Tingling	☐ Yes ☐ No	Difficulty sleeping	☐ Yes ☐ No	Urinary frequency/leakage	☐ Yes ☐ No
Urinary tract infection	☐ Yes ☐ No	Night pain	☐ Yes ☐ No	Chest pain	☐ Yes ☐ No
PMS	☐ Yes ☐ No	Coughing/sneezing	☐ Yes ☐ No	Skin rash/skin condition	☐ Yes ☐ No
Abdominal pain	☐ Yes ☐ No	Constipation/diarrhea	☐ Yes ☐ No	Bloating/gas	☐ Yes ☐ No
Nausea/vomiting	☐ Yes ☐ No	Blood in stools	☐ Yes ☐ No	Reflux/GERD	☐ Yes ☐ No

If you answered "Yes", please describe:_____

_____

Are you currently pregnant ☐ Yes ☐ No Do you smoke tobacco? ☐ Yes ☐ No

Do you drink alcohol regularly? ☐ Yes ☐ No

Have you had 2 or more falls in the past year or any fall with injury in the past year? ☐ Yes ☐ No

Please answer the following questions regarding your current condition:

Have you had any previous treatment for your current condition?

☐ Chiropractic ☐ Physical Therapy ☐ Injections ☐ Other: _____

Results:_____

Have you had any of the following diagnostic tests for your current condition?

☐ MRI ☐ X-ray ☐ CT Scan ☐ Bone Scan ☐ EMG ☐ Other: _____

Results: _____

My symptoms are: ☐ Getting Worse ☐ Staying the Same ☐ Getting Better

I currently have difficulty with the following daily activities as a result of my current condition:

☐ Standing	☐ Sitting	☐ Walking	☐ Getting Up From A Chair
☐ Bending/Lifting	☐ Sleeping	☐ Dressing/Grooming	☐ Work Activities
☐ Push/Pull/Reach	☐ Driving	☐ Balancing	☐ Eating/Digestion

☐ Other: _____

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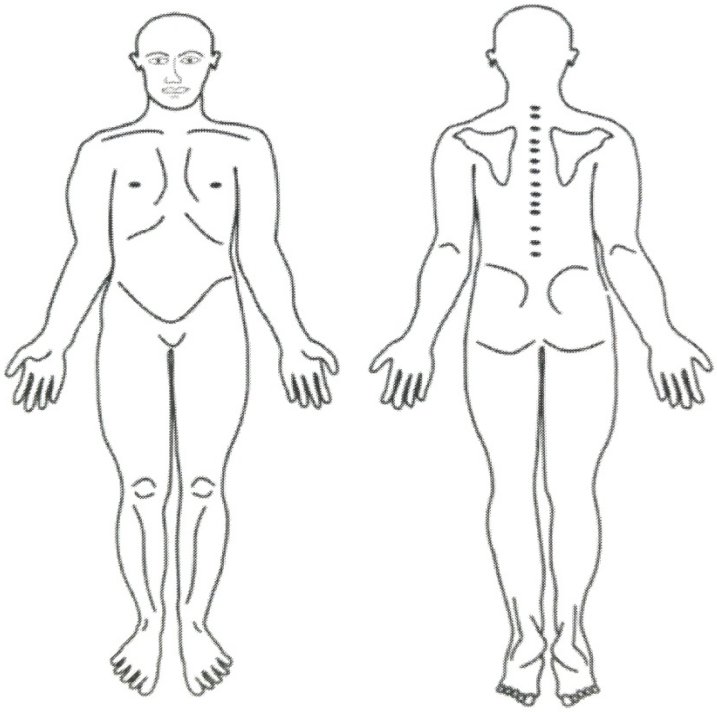
PLEASE PLACE AN "X" ON THE BODY DIAGRAM BELOW IN THE PLACES WHERE YOU ARE CURRENTLY EXPERICNING SYMPTOMS. RATE EACH "X" WITH A NUMBER FROM 0 (MEANING NO PAIN AT ALL) TO 10 (MEANING THE MOST SEVRE PAIN YOU'VE EXPERIENCED):



FROM THE LIST BELOW, PLEASE MARK THE SYMPTOMS YOU CURRENTLY EXPERIENCE:

Pressure _____	Weakness_____	Tingling _____	Clicking _____	Ache _____
Bloating _____	Burning _____	Stiffness _____	Popping _____	Numb _____
Cramping _____	Heaviness _____	Swelling _____	Pins/Needles ____	Sharp _____

RATE YOUR PAIN ON A SCALE OF 0-10 AT BEST AND AT WORST IN THE SPACES PROVIDED:

AT BEST: _____

AT WORST: _____