PHYSICAL THERAPY & SPORTS REHAB

MEDICAL HISTORY QUESTIONNAIRE

Name _____ **Age** _____ **Date** _____
Please describe your current complaint or limitation: _____
Please explain resulting functional limitation: _____
Please describe how your problem began: _____
Please tell us when your condition started: _____
What was your prior level of function: _____
Circle tests you have had: XRAY MRI OTHER: _____
Did you have surgery: NO YES Date_____

Please circle the nature of your pain:

Sharp Pain Constant
Dull (Pain) Ache Burning
Tingling Intermittent
Throbbing
Numbness
Shooting

Medications: _____

Indicate the intensity of your pain at rest: (NO Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Indicate the intensity of your pain with movement: (NO Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Since this condition began your symptoms have: decreased not changed increased

Your symptoms are worse in: morning afternoon night increased during the day same all day

Activities or positions that increase symptoms: _____

Activities or positions that decrease symptoms: _____

Occupation: _____ Has your work status changed because of this condition YES NO

If you have ever had a listed condition in the past, please in the PAST column. If you are presently troubled by a particular condition, check in the PRESENT column. The information you provide concerning past and present conditions assists your therapists in more thoroughly understanding your state of health.

Past	Present	
___	____	High Blood Pressure
___	____	Angina
___	____	Heart Attach
___	____	Stroke
___	____	Asthma
___	____	HIV/AIDS
___	____	Cancer Location _____ Date_____
___	____	Tumor
___	____	Systemic Lupus
___	____	Hepatitis
___	____	Epilepsy
___	____	Diabetic
___	____	Rheumatoid Arthritis
___	____	Arthritis
___	____	Other _____
___	____	Tobacco packs/day _____
___	____	Drug or Alcohol Dependence

Hospitalization/Surgical Procedures (list if not described elsewhere):_____
_____
_____
__

Do you have a pace maker: _____yes _____no

Medications:
_____
_____

_____
Patient Signature