KAH Premium Physical Therapy

Medical History Questionnaire

The purpose of this questionnaire is to help me understand your health status. Please complete this form and I will answer any questions during your exam. This form is to be considered part of your medical record.

Name: _________________________________ Date of Birth: ____________________
Referring Physician: ______________________
Emergency Contact Name: _________________ Phone: ____________ Cell: ____________
Date of Last General Health Check-up: ___/___/___ Occupation: ________________
Have you had Surgery for this injury? YES NO Type of Surgery/Date: ______________________

Pain: (please rate your pain by circling the applicable number) 0—1—2—3—4—5—6—7—8—9--10
No pain Moderate Severe Pain

My Pain can be best described as: (please circle all that apply)
Constant Intermittent Sharp Dull Aching Stabbing Numbness Pins/Needles

Are you currently taking any prescription or non-prescription Medications? YES NO
Anti-inflammatories Muscle Relaxers Pain Medicines Others:_______________________________________

Have you had any of the following Medical or Rehabilitative Care for this Injury/Episode?

	Yes	No		YES	NO
Chiropractor	___	___	CT Scan	___	___
General Practitioner	___	___	EMG/NCV	___	___
Occupational Therapy	___	___	MRI	___	___
Physical Therapy	___	___	Myelogram	___	___
Massage Therapy	___	___	X-Rays	___	___
Neurologist	___	___	Emergency Room Care	___	___
Orthopedist	___	___	Podiatrist	___	___

Please describe and timeline if you have answered yes to any of the above: ____________________________________
____

Do you now have, or have you ever had, any of the following?

	YES	NO		YES	NO
Asthmas, Brochitis, or Empheysema	___	___	Severe or Frequent Headache	___	___
Shortness of Breath/Chest Pain	___	___	Vision or Hearing Difficulty	___	___
Coronary Heart Disease or Angina	___	___	Numbness or Tingling	___	___
DO you have a pacemaker	___	___	Dizziness or Fainting	___	___
High Blood Pressure	___	___	Weakness	___	___
Heart Attack/Heart Surgery	___	___	Weight Loss/Energy Loss	___	___
Blood Clot/Emboli	___	___	Epilepsy/Seizures	___	___
Stroke/TIA	___	___	Neck Injury/Surgery	___	___
Allergies	___	___	Shoulder Injury/Surgery	___	___
Pins or Metal Implants	___	___	Elbow/Hand Injury/Surgery	___	___
Cancer	___	___	Back Injury/Surgery	___	___
Osteoporosis	___	___	Knee Injury/Surgery	___	___
Sleeping Problems/Difficulty	___	___	Leg/Ankle/Foot Injury/Surgery	___	___
Latex Sensitivity/Allergy	___	___	Arthritis	___	___
Infectious Disease	___	___	Joint Replacement	___	___

Other: ____

Please describe and timeline if you have answered yes to any of the above: ____________________________________
____

Patient Signature: _______________________________________ Date: _________________________
Physical Therapist Initials: __________ Date: _________________________