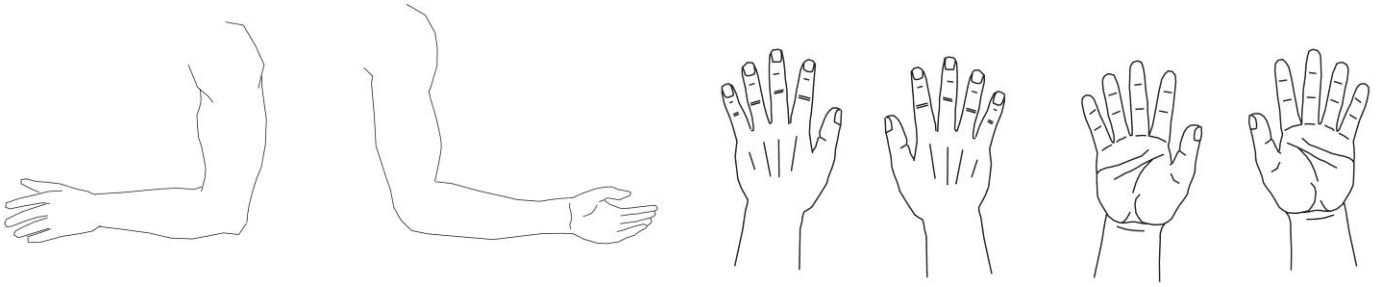
MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____

What problem are you here for today? _____ When did the problem start? _____

Describe how your problem or injury occurred: _____

Please indicate your areas of discomfort on the figures below. Draw a circle around those areas that are numb. Draw an X on those areas that are painful.



Please rate your pain on a scale of 0 to 10, with 0 indicating no pain and 10 indicating unbearable pain. Circle the number for the amount of pain you have **at rest** and **with activity**.

Pain at rest:	No Pain	0	1	2	3	4	5	6	7	8	9	10	Unbearable Pain
Pain with activity:	No Pain	0	1	2	3	4	5	6	7	8	9	10	Unbearable Pain

What is the frequency of your pain/numbness?

☐ Constant ☐ 4 or more times/day ☐ 1 to 3 times/day ☐ 4 or more times/week ☐ 1 to 3 times/week ☐ No pain

Does your pain awaken you at night? ☐ Yes ☐ No

What eases your symptoms? ☐ Heat ☐ Ice ☐ Rest ☐ Medication ☐ Change in position ☐ Other: _____

Which activities increase your symptoms? Please circle

Repetitive tasks	Walking	Twisting	Sleeping	Cold Weather	Sitting	Pushing/pulling	Reaching
Rising from chair	Lifting	Reclining	Driving	Other:			

Are you able to continue working? ☐ Yes, full duty ☐ Yes, light duty ☐ No_ Last day worked: _____

Are you able to continue your usual recreational activities? ☐ Yes ☐ No ☐ Limited - Explain: _____

What specific activities, at home or work, are you unable to perform? _____

Have you experienced any of the following recently? Please circle

Locking	Giving way	Unconsciousness	Lip numbness	Dizziness/blurred vision	Pain with cough/sneeze
Dislocating	Loss of balance	Dropping things	Neck pain/stiffness	Decreased coordination	

How is your condition progressing overall? ☐ Improving ☐ Staying the same ☐ Getting worse

Please complete other side

GENERAL HEALTH QUESTIONS

Have you had a similar problem before? ☐ Yes ☐ No If yes, when? _____

Have you had treatment for this problem before? ☐ Yes ☐ No If yes, what kind?

☐ PT ☐ OT ☐ Chiropractic ☐ Massage ☐ Splint/Brace ☐ Injections ☐ Other: _____

☐ Cast (duration:_____weeks)

Have you had any testing for your current problem? ☐ Yes ☐ No

☐ X-rays ☐ Bone scan ☐ CT scan ☐ MRI ☐ Nerve tests ☐ Blood tests ☐ Other: _____

Results of testing (if known): _____

How would you rate your overall health? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Are you currently taking any medications? ☐ Yes ☐ No If yes, please list medications below.

_____

_____

If you have any **medication allergies**, please list them here: _____

Age: _____ Height: _____ Weight: _____ Do you exercise regularly? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes, how much? _____ For how long? _____

If female, are you pregnant at this time? ☐ Yes ☐ No ☐ Not applicable

Have you had any long-term use of prednisone, cortisone, steroids or inhalants? ☐ Yes ☐ No If yes, please specify: _____

_____

Have you had any of the following at any time in your life? Please circle

Polio	Asthma	Allergies	Fibromyalgia	Tuberculosis	Lung problem	Allergy to latex
Lupus	Hepatitis	Phlebitis	Blood clots	Osteoporosis	Heart disorder	Allergy to adhesives
Stroke	Seizures	Diabetes	Concussion	Sprain/Strain	Hypoglycemia	Bleeding disorder
Cancer	Arthritis	Whiplash	Broken bone	Metal implant	Nerve disorder	High blood pressure
Connective tissue disorder		Unusual/frequent headaches		Major accident with injuries/fractures		Kidney disease

Orthopedic Surgery (bones or joints): _____ Other surgery: _____

Please explain any circled items: _____

_____

What are your goals and expectations for Physical/Occupational Therapy? _____

_____

How did you hear about us? Please circle all that apply

Aquasox Attorney Drive by Friend/Family Insurance Company Doctor School Website Yellow Pages Other

Patient Signature: _____ Date: _____