SPECTRUM Therapy

PHYSICAL THERAPY

MEDICAL HISTORY QUESTIONNAIRE

Please Print

Name:_____ DOB:_____ Age:_____ Date:_____

Referring Physician: _____

Reason for Visit: _____

When did this injury/problem occur? _____

If you are experiencing pain, HOW did it occur? _____

What difficulties are you having with this injury? _____

What positions/activities improve your symptoms? _____

_____

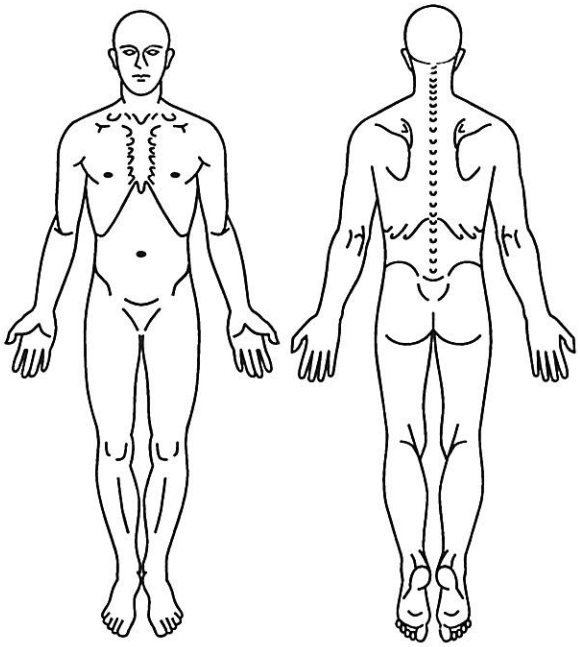
What positions/activities make your symptoms worse? _____

_____

Are your symptoms: ❑ getting worse ❑ improving ❑ the same

PAIN DIAGRAM

Please use the following diagram below to indicate where you feel your symptoms currently.
Use the key below to indicate the different types of symptoms.



KEY

Pins & Needles = 00000

Stabbing = /////

Burning = XXXXX

Deep Ache = zzzzz

Please rate your pain using the following scale:

0	1	2	3	4	5	6	7	8	9	10
(no pain)										(worst Imaginable pain)

Today: _____/10 **At Best: _____/10** **At Worst: _____/10**

Name: _____ DOB: _____

CURRENT CONDITIONS/SYMPTOMS:

(please check all that apply)

- ❑ Nausea/Vomiting
- ❑ Pregnancy
- ❑ Fainting
- ❑ Dizziness
- ❑ Headaches
- ❑ Fatigue
- ❑ Fever/Chills/Sweating
- ❑ Pain at night
- ❑ Unexplained weight change
- ❑ Shortness of breath

What medications are you currently taking? _____

_____

Please check and date any pertinent diagnostic test:

❑ x-ray: _____ ❑ MRI: _____ ❑ Bone Scan: _____ ❑ Other: _____

Please list any previous treatment(s) you've had for this condition: _____

_____

Do you have a problem with: ❑ speech ❑ vision ❑ hearing ❑ communication

PAST MEDICAL HISTORY:

(please check all that apply)

- ❑ **No Significant History**
- ❑ Alzheimer's Disease
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood Clots
- ❑ Bowel/Bladder Problems
- ❑ Cancer
- ❑ Circulatory Disease
- ❑ Depression/Anxiety
- ❑ Diabetes
- ❑ DVT (blood clot)
- ❑ Eating Disorder
- ❑ Emphysema/Bronchitis (COPD)
- ❑ Epilepsy
- ❑ Gout
- ❑ Heart Attack
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Latex Allergy
- ❑ Multiple Sclerosis
- ❑ Osteoporosis
- ❑ Pacemaker/Metal/Other Implants
- ❑ Psycological Disorder
- ❑ Rheumatoid Arthritis
- ❑ Scoliosis
- ❑ Sexual Dysfunction
- ❑ Sleep Apnea
- ❑ Stroke
- ❑ Substance Abuse Problem
- ❑ Thyroid Problems
- ❑ Tuberculosis

FAMILY MEDICAL HISTORY:

- ❑ Unknown
- ❑ No significant history
- ❑ Arthritis
- ❑ Cancer _____
- ❑ Diabetes
- ❑ Heart Disease
- ❑ Other _____

Please list any prior injuries/surgeries: _____

_____

SOCIAL HISTORY:

Please list your leisure/fitness activities: _____

Date of last physical: _____ Do you use tobacco? ❑ yes ❑ no Do you drink alcohol? ❑ yes ❑ no

What is your employment status? (please circle):

Full Duty Restricted Duty Temporary Leave Retired (date_____) Disabled (date_____) Unemployed

Your goals for therapy: _____

_____