Dubuque Physical Therapy

Medical History Questionnaire

Patient Name		Date of Birth		Age	
Emergency Contact		Phone Number		Relationship	
Reason for Therapy				Date of Injury or Onset	

Is the Reason for Therapy Accident Related? ☐ No ☐ Yes

If yes, please check one: ☐ Accident ☐ Auto ☐ Work ☐ Other If other, please explain:

Are you **currently** receiving any other care for the condition mentioned above? ☐ No ☐ Yes If yes, please list:

Have you ever received therapy **in the past** for the condition mentioned above? ☐ No ☐ Yes If so, when?

Previous Treatment Received:

Previous Treatment: ☐ Successful ☐ Unsuccessful

Have you received therapy services for **other problems/conditions during this calendar year**? ☐ No ☐ Yes If yes, please list:

Could you be or are you pregnant? ☐ **No** ☐ **Yes**

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

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Arthritis	☐	☐	**Diabetes**	☐	☐	**Numbness / Tingling**	☐	☐
Osteoporosis	☐	☐	**Anemia**	☐	☐	**Thyroid Problems**	☐	☐
High Blood Pressure	☐	☐	**Swelling in Ankles**	☐	☐	**Headaches**	☐	☐
Heart Disease / Heart Attack	☐	☐	**Deep Vein Thrombosis (DVT)**	☐	☐	**Head Injury / Concussion**	☐	☐
Pacemaker	☐	☐	**Seizures / Epilepsy**	☐	☐	**Hernia**	☐	☐
Stroke	☐	☐	**Fatigue / Weakness**	☐	☐	**Kidney / Bladder Problems**	☐	☐
Vascular Disease	☐	☐	**Cancer / Tumor**	☐	☐	**Previous Fractures**	☐	☐
Hypersensitivity to Heat/Cold	☐	☐	**Recent Weight Loss or Gain**	☐	☐	**Previous Surgeries**	☐	☐
Asthma	☐	☐	**HIV / AIDS**	☐	☐	**Metal in Body or Surgical Implants**	☐	☐
Shortness of Breath	☐	☐	**Hepatitis**	☐	☐	**Depression**	☐	☐
Chronic Cough	☐	☐	**Tuberculosis**	☐	☐	**Anxiety**	☐	☐
Dizziness / Light Headed-ness / Fainting Spells	☐	☐	**Recurrent Infection(s) or Infection in past 3 months**	☐	☐	**Smoking**	☐	☐
Nausea / Vomiting	☐	☐	**Fever / Chills**	☐	☐	**Other (please describe below)**	☐	☐

If you answered "yes" on any of the above or have other conditions not listed, please explain and give approximate date(s):

Do you have any allergies? ☐ No ☐ Yes, list allergies:

Are you presently taking any medications? ☐ No ☐ Yes, list medications and specify condition:

At the present time, would you say that your health is (circle one): Excellent Very Good Fair Poor

The information is correct to the best of my knowledge.

X

Patient/Parent/Guardian Signature | Date

Pain Diagram and Pain Rating

Name: ______________________________ **Date:** /_____/_____

INSTRUCTIONS: Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Use the key to indicate the type of symptoms.

KEY:

Pins and Needles	**= 000000**	**Stabbing**	**= //////**
Burning	**= xxxxxx**	**Deep Ache**	**= zzzzzz**

Please rate your current level of pain on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10

(no pain) (worst imaginable pain)

Please rate your worst level of pain in the last 24 hours on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10

(no pain) (worst imaginable pain)

Please rate your best level of pain in the last 24 hours on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10

(no pain) (worst imaginable pain)