Andersonville Physical Therapy

INITIAL MEDICAL HISTORY QUESTIONNAIRE

_____ _____ _____ _____

FIRST NAME LAST NAME AGE DATE OF BIRTH

What problem/issue brings you in today? _____

_____

What date (roughly) did your present symptoms start? _____

How did this issue begin? _____

_____

What makes your symptoms *better*? _____

What makes your symptoms *worse*? _____

My symptoms currently: *come and go* *are constant* *are constant, but change with activity*

Rate your pain on a scale of 0-10 (0=no pain; 10=worst pain): _____ _____ _____

CURRENT BEST WORST

Please describe your pain (circle all that apply):

dull *achy* *burning* *stabbing* *numbness* *tingling* *tightness*

What time of day are your symptoms the worst? *morning* *afternoon* *evening* *overnight*

What treatments have you received so far for this issue (circle all that apply)?

massage *injections* *psychotherapy* *chiropractic* *physical therapy*

What has helped? _____

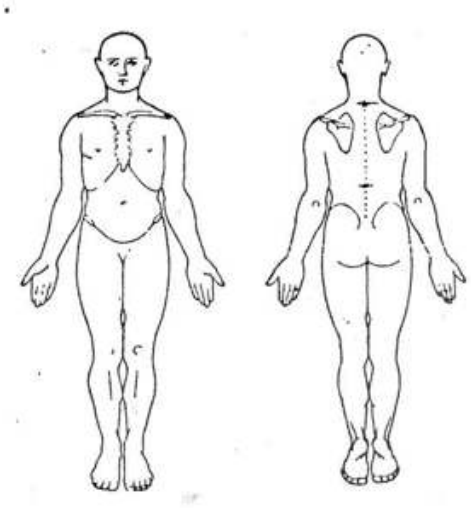
Approximately how many PT sessions have you received this calendar year? _____

What diagnostic tests have you had for this problem (circle all that apply)?

x-ray *MRI* *CT scan* *bone scan* *EMG* *other*

What were the results? _____

Please circle the areas where you are experiencing your symptoms on the drawings to the right:



-MEDICAL HISTORY-

Have you recently experienced any of the following (check all that apply)?

___ *Changes in bowel/bladder function*
___ *Shortness of breath*
___ *Nausea/vomiting*
___ *Weakness/fatigue*
___ *Loss of control of urine*
___ *Headaches*
___ *Dizziness/lightheadedness*
___ *Difficulty maintaining balance while walking*
___ *Difficulty swallowing*
___ *Unintended weight loss/gain*
___ *Numbness/tingling*
___ *Fever/chills/sweats*
___ *Pain at night*
___ *Changes in appetite*
___ *Pain caused by cough or sneeze*
___ *Frequent falls*

Please explain: _____

_____

Please describe any surgical history (include dates): _____

_____

Other medical history (check all that apply):

___ *Diabetes*
___ *Cancer*
___ *High blood pressure*
___ *Cardiovascular conditions*
___ *Rheumatoid arthritis*
___ *Osteoarthritis*
___ *Fractures*
___ *Motor vehicle accidents*
___ *Osteoporosis*
___ *HIV*
___ *Immunosuppression*
___ *Neurological conditions*
___ *Chronic aches/pain*
___ *Stroke/TIA*
___ *Current infection*

Please explain: _____

_____

During the past month, have you been experienced feelings of depression or hopelessness? *yes* *no*

Do you have any allergies? If yes, please list them: _____

_____

- MEDICATIONS -

Please list all medications, vitamins, supplements and over-the-counter drugs you are currently taking.

MEDICATION NAME	**HOW MUCH (DOSE)**
_____	_____
_____	_____
_____	_____
_____	_____

-LIFESTYLE HISTORY-

What is your occupation? _____

How much are you currently working? *light duty* *full duty* *not working*

If not working, please indicate the date last worked: _____

Physical requirements of occupation (circle all that apply):

prolonged sitting *prolonged standing* *lifting* *travel* *driving* *computer* *phone* *childcare*

Do you live alone? *yes* *no*

Please circle the option that is closest to your residence type:

house *apartment/condo* *group residence* *nursing home*

Leisure activities/hobbies/exercise routine: _____

_____

What activities generally comprise your day (circle all that apply)?

sitting *standing* *walking* *lifting* *other:*_____

In which position do you sleep? *back* *stomach* *side*

Do you use tobacco? *yes* *no*

If yes, please indicate type, amount and frequency: _____

Is there anything else we should know that is pertinent to your treatment? _____

_____

_____

_____

_____

_____

_____