Twin Lakes
PHYSICAL THERAPY

MEDICAL HISTORY QUESTIONNAIRE

Patient Name:_____Date:_____

Date of Injury/Onset:_____/_____/_____ Height_____ Weight

Next Physician Visit:_____/____/_____ Referring Physician:_____

Have you ever had these symptoms before? ☐ **YES** ☐ **NO** Previous injuries related to your current symptoms? _____

_____

Check which apply to your symptoms:

- ☐ Work Related Injury
- ☐ Athletic/Recreational Injury
- ☐ Motor Vehicle Accident
- ☐ Other: _____
- ☐ Unknown
- ☐ Reoccurrence of previous injury
- ☐ Injury related to falling
- ☐ Surgery – Date____/____/_____

Do you participate in any sports activities on a regular basis? ☐ **YES** ☐ **NO** If yes, please list:

_____

Do you have, or have you had any of the following:

☐ Diabetes	☐ Bowel/Bladder Abnormalities	☐ Hernia
☐ Chest Pain/Angina		☐ Seizures
☐ High Blood Pressure	☐ Urine Leakage	☐ Metal Implants
☐ Heart Disease	☐ Asthma/Breathing Difficulties/COPD	☐ Dizziness/Fainting
☐ Heart Attack		☐ Recent Fractures
☐ Heart Palpitations	☐ Liver/Gallbladder Problems	☐ Surgeries
☐ Pacemaker	☐ Smoking	☐ Skin Abnormalities
☐ Headaches		☐ Sexual Dysfunction
☐ Kidney Problems	☐ Motion Sickness	☐ Nausea/Vomiting
☐ Pregnant	☐ Allergies to Aspirin	☐ Ringing in your ears
☐ Cancer	☐ Allergies to Heat	☐ Rheumatoid Arthritis
☐ Osteoarthritis	☐ Poor Tolerance to Cold	☐ Hypoglycemia
	☐ CVA/Stroke	☐ Falls within the last year #

Any other information regarding your past medical history that we should know about?

_____

_____

_____

Are you presently taking medication? ☐ **YES** ☐ **NO** If yes, please list what medications and for what condition?_____

_____

_____

Regarding your current symptoms have you had: ☐ **X-RAYS** ☐ **MRI** Date: _____

How did your injury occur? _____

_____

What is your primary complaint? _____

_____

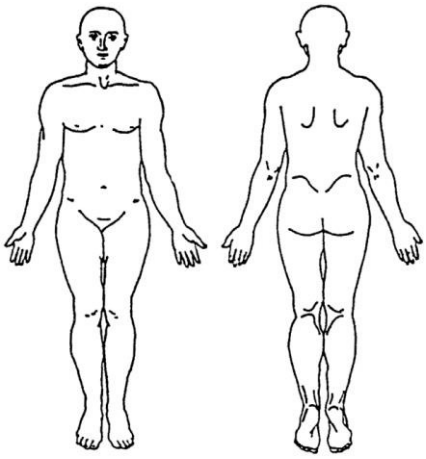
What is your goal for treatment? _____

_____

Rate your pain on a scale from 0-10, with 0 being NO pain, and 10 being the worst pain imaginable:

The worst it becomes:_____The Average:____Now: _____

Patient Signature:_____
Date: _____



Please indicate on the figure above where your symptoms are located. **KEY:**
X - Achy Pain
O - Numbness / Burning / Sharp pain