Twin Lakes
PHYSICAL THERAPY

MEDICAL HISTORY QUESTIONNAIRE

Patient Name:_____ Date:_____

Date of Injury/Onset: ____/_____/_____

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
- ☐ Chest Pain/Angina
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Heart Palpitations
- ☐ Pacemaker
- ☐ Headaches
- ☐ Kidney Problems
- ☐ Pregnant
- ☐ Cancer
- ☐ Abnormalities
- ☐ Bowel/Bladder Abnormalities
- ☐ Urine Leakage
- ☐ Asthma/Breathing Difficulties
- ☐ Liver/Gallbladder Problems
- ☐ Smoking
- ☐ Motion Sickness
- ☐ Allergies to Aspirin
- ☐ Allergies to Heat
- ☐ Poor Tolerance to Cold
- ☐ Special Diet Guideline
- ☐ Hernia
- ☐ Seizures
- ☐ Metal Implants
- ☐ Dizziness/Fainting
- ☐ Recent Fractures
- ☐ Surgeries
- ☐ Skin Abnormalities
- ☐ Sexual Dysfunction
- ☐ Nausea/Vomiting
- ☐ Ringing in your ears
- ☐ Rheumatoid Arthritis
- ☐ Hypoglycemia
- ☐ Other:_____

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? _____

_____

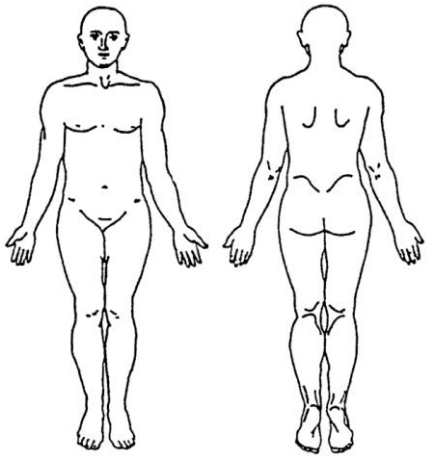
What is your goal for treatment? _____

_____

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 least: _____ Now: _____

Patient Signature: _____
Date: _____



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