Date: Weight:

Name: Height:

DOB: Age:

Phone: Smoker: **Y / N**

email: Pregnant: **Y / N / ?**

occupation:

Medical Questionnaire

What is your current-primary symptom/complaint?:____

____

When did symptom begin?____(**suddenly / gradually / injury**)

Have you received any treatment for this problem? **Y / N** what / when?________________________________

If any, what treatments have worked?____

If any, what treatments have failed?____

What aggravates your symptoms?____

What improves your symptoms?____

Have you had x rays, MRI, EMG, CT scan for this problem? **Y / N**
What were the results:____

Are you currently being seen by a home health agency? **Y / N** Do you have a TENS device? **Y / N**

Medical History: Please list any medical conditions and/or illnesses that you have or have had in the past:

____

____

Surgical History: Please list any surgeries that you have had either recently or in the distant past:

____

In the past month, have you often been bothered by little interest/pleasure in doing things? **Y / N**
In the past month, have you often been bothered by feeling down, depressed, or hopeless? **Y / N**
Would you like help with these feelings? **Yes - today.** **Yes - not today.**

Please list all of the medications that you are currently taking: (if more than three, then please bring a list of medications):

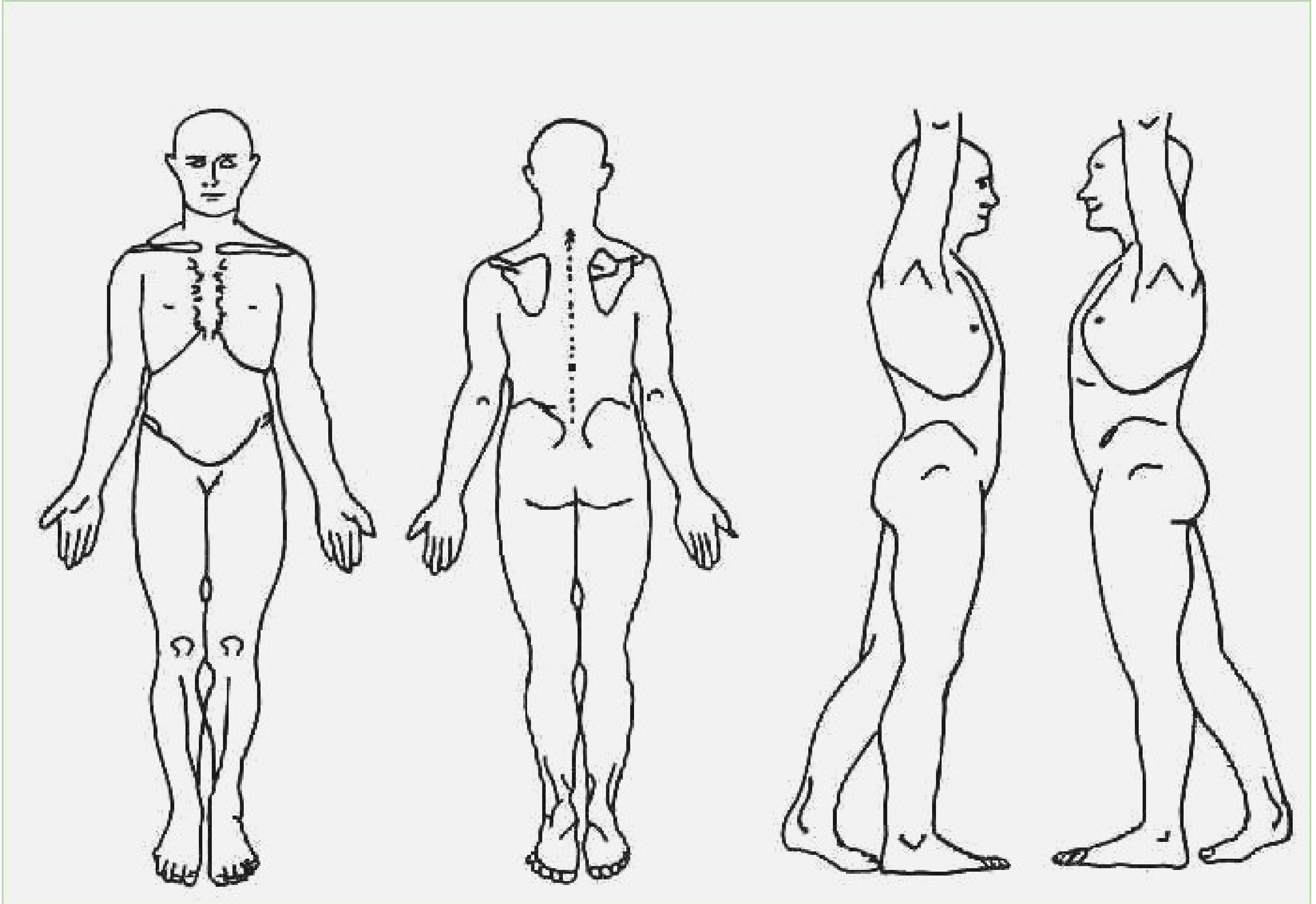
(over)

On the scales below, please circle the numbers which best represent the severity of your pain with **0 being no pain** and **10 being the worst pain**:

Worst Pain:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10
Lowest Pain:	0	1	2	3	4	5	6	7	8	9	10

How would you describe your pain? ____

(please indicate where you feel your pain on the diagram below)



As a percentage, what is your overall functional level between 0 and 100%?:___________________

Are there any specific activities that you are unable to perform or are having difficulty with as a result of your problem?

____

____

What is your goal for physical therapy?____

Is there anything else that you'd like to inform your therapist about? ________________________

How many days per week do you exercise?____

____

(please sign and date)