Medical History Questionnaire

Name____

Age: _______ Date of Birth (mm/dd/yyyy): _____________

Referring Physician____

Date of 1st MD visit_______________ Next MD visit_____________

Occupation____________________________ Last Date Worked Due to this Injury _____________

Date Returned________________

Have you had Surgery for this injury (Y/N)? ______ Type of Surgery/Date__________________________________

Are you taking any prescription or non-prescription medications for this injury? (Please list)

____ ____

____ ____

____ ____

Are you taking any prescription or non-prescription medications for any other medical conditions? (Please list)

____ ____

____ ____

____ ____

____ ____

Have you had any medical or physical therapy care for this injury? If yes, when and what

	Yes	No	Date		Yes	No	Date
Chiropractor	___	___	_______	CT Scan	___	___	_______
Emergency Room	___	___	_______	EMG/NCV	___	___	_______
General Practitioner	___	___	_______	MRI	___	___	_______
Occupational Therapy	___	___	_______	Myelogram	___	___	_______
Physical Therapy	___	___	_______	X-Rays	___	___	_______
Massage Therapy	___	___	_______	Neurologist	___	___	_______
Orthopedist	___	___	_______	Podiatrist	___	___	_______

MATRIX
PHYSICAL THERAPY, LLC

Do you have or have you ever had ANY of the following?

	Yes	No		Yes	No
Asthma	___	___	Vision Difficulty	___	___
Bronchitis	___	___	Hearing Difficulty	___	___
Emphysema	___	___	Dizziness or Fainting	___	___
Shortness of Breath	___	___	Weak ness	___	___
Coronary Artery Disease	___	___	Weight Loss	___	___
Angina	___	___	Energy Loss	___	___
High Blood Pressure	___	___	Hernia	___	___
Heart Attack/Heart Surgery	___	___	Epilepsy/Seizures	___	___
Pacemaker	___	___	Thyroid trouble/Goiter	___	___
Stroke/TIA	___	___	Blood Clot/Emboli	___	___
Allergies	___	___	Headaches	___	___
Metal Implants/Pins	___	___	Incontinence	___	___
Joint Replacement	___	___	Bowel/Bladder Problem	___	___
Diabetes	___	___	Neck Injury/Surgery	___	___
Infectious Disease	___	___	Shoulder Injury/Surgery	___	___
Cancer	___	___	Elbow or Hand Injury/Surgery	___	___
Arthritis	___	___	Back Injury/ Surgery	___	___
Osteoporosis	___	___	Knee Injury/Surgery	___	___
Difficulty Sleeping	___	___	Leg/Ankle/Foot Injury/Surgery	___	___
Neurological Problems	___	___	Gout	___	___
Varicose Veins	___	___	Fibromyalgia	___	___
Emotional Problems	___	___	Chronic Fatigue	___	___
Vascular Problems	___	___	Anemia	___	___
Lyme Disease	___	___	Shingles	___	___

Do you smoke? ___ ___

Are you pregnant? ___ ___

Please list any injury or illness not listed above ____

____

Please elaborate on any "Yes" answers above requiring further information

____

____

____

____

When did you first notice you symptoms? ____

Gradual or sudden onset? ______________

Have your symptoms changed since onset (Y/N)?

How? ____

Pain (draw letter to indicate intensity B=best; W=worst in the past 72 hours)

0_____________________5_____________________10
No pain Unbearable

Is your pain constant or intermittent? ____

Is there a better or worse time of day? ____

What activities/motions exacerbate your symptoms?

____

What can you do to alleviate your pain?

____

What activities have been affected or modified?

____

What sports or recreational activities to you want to return to?

____

What do you want to get out of therapy?

____

Anything else we should know about/precautions:

____

____

____

Patient/Guardian Signature______________________________________**Date**____________________