INSPIRE PHYSICAL & HAND THERAPY

MEDICAL QUESTIONNAIRE

Medical Questionnaire

Patient Name:_____ Date_____ Date of Birth_____Age____

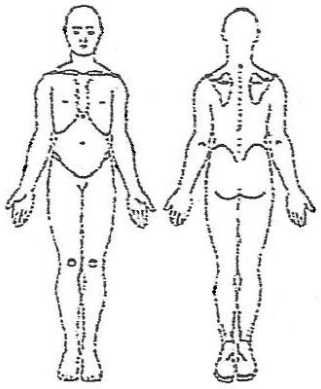
Occupation:_____ Employer:_____ Hrs/Wk_____

What problem or diagnosis brings you here today?_____

Side of Injury: ◯ R ◯ L Date of Injury?_____ Who referred you to PT?_____

Briefly describe your symptoms:_____

Describe how your condition or injury occurred:_____



⇦ Shade your areas of pain or discomfort on the figures to the left:

Please rate your pain on the scale below from 0 to 10:
(0=no pain; 10=worst pain imaginable/emergency room pain)

Pain at rest: ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

Pain with activity: ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

What is the frequency of your pain? ◯Constant ◯Intermittent

Does your pain wake you at night? ◯Y ◯N

How many times?_____

What eases your symptoms?_____

What aggravates your symptoms?_____

Are your symptoms getting ◯Better ◯Worse ◯Same Is your pain worse in the ◯AM ◯PM ◯Mid-Day

Are you currently working? ◯Y ◯N Are you currently on: ◯Light duty ◯Normal Duty

Is this a Motor Vehicle claim? ◯Y ◯N

What activities at home, work or recreational are you unable to perform?_____

Have you had a similar condition before? ◯Y ◯N If yes, when_____

Have you had tests for this condition? ◯Y ◯N If yes, results:_____

CIRCLE tests: X-Rays MRI Bone Scan CT Scan Nerve Tests Blood Tests Other_____

Have you had any other treatment for this condition? ◯Y ◯N

If yes, what Kind? ◯PT ◯OT ◯Chiropractic ◯Massage

CIRCLE Current Level of Physical Activity: ◯High ◯Medium ◯Low List:_____

What goals do you hope to accomplish with Physical Therapy?_____

Medical History (Check all that apply)

☐ Angina/Chest Pain	☐ Cancer	☐ Hearing Problems	☐ Osteoporosis
☐ Asthma	☐ Depression	☐ Heart Disease	☐ Pacemaker/Nitroglycerin
☐ Arthritis	☐ Diabetes	☐ Hepatitis	☐ Poor Circulation/Raynaud's
☐ Blackouts	☐ Diverticulitis	☐ High Blood Pressure	☐ Polio
☐ Blindness	☐ Ear Infections	☐ High Cholesterol	☐ Seizures
☐ Blood Clot	☐ Endometriosis	☐ Hypoglycemia	☐ Stroke
☐ Bowel or Bladder Problems	☐ Fibroids	☐ Menopause	☐ TB
☐ Carpel Tunnel Syndrome	☐ Fibromyalgia	☐ Migraine Headaches	☐ Traumatic Injury/MVA
☐ Chest/Abdominal Surgery	☐ Fractures	☐ Major spinal issues	☐ Other
☐ Coronary Artery Disease	☐ Frequent Falls	☐ MRSA	

Are you Pregnant? ◯Y ◯N

Do you have a history of whiplash or low back pain? ◯Y ◯N If so, when/how long?_____

Do you smoke tobacco? ◯Y ◯N If yes, how much?_____ How long?_____

Medications/Allergies/Surgeries

List current medications:_____

List current allergies:_____

List all surgeries:_____

Signature_____ **Date**_____