Centralia Physical Therapy   Chehalis Physical Therapy

MEDICAL QUESTIONNAIRE – Physical Therapy

Name____________________________________ DOB______________ Age_____ Occupation________________________

What problem/issue brings you here today? ____

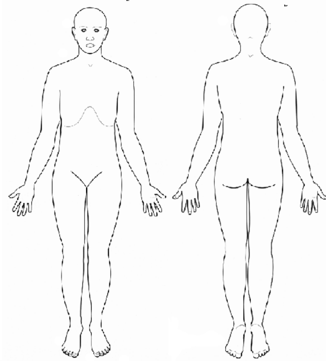
How did you hear about our clinic?____

Side of Injury ◯ R ◯ L ◯ B   Approx. Date of Injury/Surgery or Onset of Pain?______________________________

Briefly describe your symptoms:____

Describe how your condition/injury occurred:____

Shade your areas of pain/numbness/tingling/discomfort on the figures below:



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? ◯ Yes ◯ No   How many times?_______________

What eases your symptoms?____

What aggravates your symptoms?____

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

Are you currently working? ◯ Y ◯ N   Are you on ◯Light Duty ◯Normal Duty ?   Is this an Auto 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:____

Check tests: ◯X-Rays ◯MRI ◯Bone Scan ◯CT Scan ◯Nerve Tests ◯Blood Tests ◯Other___________________

Have you had other treatment for this condition? ◯Y ◯N If yes, what kind? ◯PT ◯Injection ◯Chiropractic ◯Massage

Current Level of Physical Activity: ◯ High ◯ Medium ◯ Low   List Activities:______________________________

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

MEDICAL HISTORY – Check any that apply

◯Angina/Chest Pain	◯Cancer	◯Hearing Problems	◯MRSA	◯Whiplash
◯Asthma	◯Depression	◯Heart Disease	◯Osteoporosis	◯Other-
◯Arthritis	◯Diabetes- Type: 1 2	◯Hepatitis	◯Pacemaker/Nitroglycerin	___________
◯Blackouts	◯Diverticulitis	◯High Blood Pressure	◯Poor Circulation/Raynaud's	___________
◯Blindness	◯Ear Infections	◯High Cholesterol	◯Polio	___________
◯Blood Clot(s)	◯Endometriosis	◯Hypoglycemia	◯Seizures	___________
◯Bowel/Bladder Problems	◯Fibroids	◯Low Back Pain	◯Stroke	
◯Carpal Tunnel Syndrome	◯Fibromyalgia	◯Menopause	◯TB	Are you
◯Chest/Abdominal Surgery	◯Fractures	◯Migraine Headaches	◯Traumatic Injury/MVA	Pregnant?
◯Coronary Artery Disease	◯Frequent Falls	◯Major Spinal Injury	◯Weight Loss (Unexplained)	◯ Y ◯ N

Do you smoke tobacco? ◯ Y ◯ N   If yes, how much?__________________   For how long?___________________

List current MEDICATIONS:____

List current ALLERGIES:____

List all SURGERIES:____

Signature_________________________________   **Date**____________________