

## **MEDICAL QUESTIONNAIRE**

| Occupation   | Name                                   | DC                            | DB Age  | Height Weight  |                           |
|--|--|-------------------------------|---|--|---------------------------|
| What problem/issue brings you here today?  Side of Injury \ R \ L 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 0 1 0 2 3 4 5 6 6 7 8 9 10  Pain with activity: 0 0 1 0 2 3 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 agaravates your symptoms?  Are you currently working? Y N Are you on Olight 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 sa similar condition before? Y N If yes, when?  Have you had sa similar condition before? Y N If yes, results:  Check tests: N-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 Oinjection Chiropractic Massage  Current Level of Physical Activity: High Medium Low List Activities:  What goals do you hope to accomplish with Physical Therapy?  Plagina/Chest Pain Cancer-active/remission Heart Disease Poor Circulation/Raynaud's Other-Attritis Depression High Blood Pressure Stroke  Blackouts Oblabetes-Type 1 or 2 High Cholesterol Tuberculosis  Plackouts Diabetes-Type 1 or 2 High Cholesterol Tuberculosis  Blackouts Diabetes-Type 1 or 2 High Cholesterol Tuberculosis  Blackouts Diabetes-Type 1 or 2 High Cholesterol Tuberculosis  Pregnant?  Occappal Tunnel Syndrome Pibromyalgia Major Spinal Injury  No Janual Stranger Prequent Tells*  Occappal Tunnel Syndrome  Prequent Tells*  Occappal T |  |                               |   |  |                           |
| Side of Injury \ R \ L \ Approx. Date of Injury/Surgery or Onset of Pain?  Briefly describe your symptoms:  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 0 1 2 3 3 4 5 6 7 8 9 10  Pain with activity: 0 0 1 2 3 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 aggravates your symptoms?  Are you currently working? \ Y \ N \ Are you on \ Light Duty \ Normal Duty? \ Is this an Auto claim? \ Y \ N  What a stiff it from, work or recreational) are you unable to perform?  Have you had tests for this condition? \ 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:  MEDICAL HISTORY - Check any that apply  Pagina/Chest Pain \ Cancer-active/remission \ Heart Disease \ Poor Circulation/Raynaud's \ Other-  Jathma \ Dilatory \ Covid-19 \ Hepatitis \ Diepression \ High Blood Pressure \ Setzures \ Setzures \ Menoglus Sinder Sinder Sinder \ Menoglus Sinder Sinder Sinder Sinder Sinder \ |  |                               |   |  |                           |
| 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 0 1 0 2 3 4 5 6 6 7 8 9 10  Pain with activity: 0 0 1 0 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 activities (at home, work or recreational) are you unable to perform?  Have you had a similar condition before? Y N N Are you unable to perform?  Have you had a similar condition before? Y N If yes, when?  Have you had other treatment for this condition? Y N If yes, wend kind? PT Injection Chiropractic Massage  Current Level of Physical Activity: O High Medium O Low List Activities:  What goals do you hope to accomplish with Physical Therapy?  AEDICAL HISTORY - Check any that apply  Dangina/Chest Pain Cancer-active/remission Heart Disease  Poor Circulation/Raynaud's Other-Dashman History of Covid-19 Hepatitis Seizures  Place Have you had other treatment for this condition? Hepatitis Seizures  What goals do you hope to accomplish with Physical Therapy?  AEDICAL HISTORY - Check any that apply  Dangina/Chest Pain Cancer-active/remission Heart Disease  Poor Circulation/Raynaud's Other-Dashman History of Covid-19 Hepatitis Seizures  What goals do you for the conditions Hypogycemia Transmatic Injury/MVA  Blood Otolts) Endometriosis Menopause Weight Loss (unexplained)  Bloowel/Bladder Problems Fibromyalgia Major Spinal Injury  Chest/Abdominal Surgery Fractures Marso Marso Pacemaker/Nitroglycerin Y N Prepannt?  | Side of Injury $\bigcap R$ $\bigcap I$ | Approx. Date of Injury/       | Surgery or Onset of Pain?                     |  |                           |
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| Co = no pain; 10 = worst pain imaginable/emergency room pain   | Silaue your areas or pain              |                               | _   |  |                           |
| Pain at rest: 0  | $\cap$                                 |                               | -   | <u></u>  |                           |
| Pain with activity: 0 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 aggravates 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 Olight 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 Onjection Chiropractic Massage Current Level of Physical Activity: High Medium Low List Activities: What goals do you hope to accomplish with Physical Therapy?  AREDICAL HISTORY - Check any that apply Nagina/Chest Pain Cancer-active/remission Heart Disease Poor Circulation/Raynaud's Other-Nathma History of Covid-19 Hepatitis Seziures  Arthritis Depression High Blood Pressure Stroke Blood Clot(s) Endometriosis Menopause Weight Loss (unexplained) Blood Clot(s) Endometriosis Major Spinal Injury Chest/Abdominal Surgery Fractures Massage Preguent Falls* Osteoporosis Pregnant?  **Have you had 2 or more falls in the past 12 months? Y N P Do you use tobacco products? Y N If yes, how much?  List current MEDICATIONS: List all SURGERIES:  List all SURGERIES:   What as a you at night? Yes N B How many times?  Non a treight and the past 12 months? Y N B  Toes a specific products of your and the past 12 months?  To how long?  List current MEDICATIONS: List current MEDICATIONS: List current MEDICATIONS: List current MEDICATIONS:   |  |                               |   |  |                           |
| What is the frequency of your pain?  | 11 11 11 11                            | Pain at rest: O               | $\bigcirc 1 \bigcirc 2 \bigcirc 3 \bigcirc 4$ | $1 \bigcirc 5 \bigcirc 6 \bigcirc 7 \bigcirc 8 \bigcirc 9$ | <b>○</b> 10               |
| What is the frequency of your pain?  | // // // //                            | Pain with activity            | <i>y</i> :  ○0  ○1  ○2  ○3                    | 3 \( \)4 \( \)5 \( \)6 \( \)7 \( \)8                       | ○ 9    ○ 10               |
| What eases your symptoms?  What aggravates your symptoms?  What aggravates your symptoms?  Are your symptoms getting   Better   Worse   Same ? Is pain worse in the   AM   PM   Mid-Day ? Are your 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 ests for this condition?   Y   N   If yes, results:  Check tests:   X-Rays   MRI   Bone Scan   CCT 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?  AREDICAL HISTORY - Check any that apply  Angina/Chest Pain   Cancer-active/remission   Heart Disease   Poor Circulation/Raynaud's   Other-  Jakshma   History of Covid-19   Hepatitis   Seizures    Jakshma   Depression   High Blood Pressure   Stroke    JBlackouts   Diabetes- Type 1 or 2   High Cholesterol   Tuberculosis    JBlindness   Ear Infections   Hyoglycemia   Traumatic Injury/MVA    JBlood Clot(s)   Endometriosis   Menopause   Weight Loss (unexplained)    JBowel/Bladder Problems   Fibroriols   Major Spinal Injury    Carpal Tunnel Syndrome   Fibromyalgia   Major Spinal Injury    Chest/Abdominal Surgery   Fractures   MRSA   Are you    Pregnant?    Coronary Artery Disease   Hearing Problems   Problems   Proplems    Heart problems   Frequent Falls*   Osteoporosis   Pregnant?    Thow you had 2 or more falls in the past 12 months?   Y   N    Do you use tobacco products?   Y   N   If yes, how much?   For how long?    List current MEDICATIONS:    List all SURGERIES:    List all SURGERIES:   |  | w                             | ,, 0, 0, 0, 0,                                |  |                           |
| What eases your symptoms?  What aggravates your symptoms?  Are your symptoms getting   | 1 1 1 1 1 1                            | What is the frequency         | uency of your pain? 0                         | Constant   |                           |
| What eases your symptoms?  What aggravates your symptoms?  Are your symptoms getting   | ( )( )                                 | De se veve meio v             | valsa vav at niaht2                           | on ONe Herringen times 2                                   |                           |
| What aggravates your symptoms?  Are your symptoms getting  | ){/( }//}                              | Does your pain v              | vake you at night? O Ye                       | s \(\int\) NO How many times?_                             |                           |
| What aggravates your symptoms?  Are your symptoms getting  | What eaces your sympton                | mc?                           |   |  |                           |
| Are your symptoms getting  | What aggravates your sympton           | mntoms?                       |   |  |                           |
| Are you currently working?   |  |                               |   |  | id Day 2                  |
| 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 Olnjection 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-active/remission Heart Disease Poor Circulation/Raynaud's Other-Atthritis Depression High Blood Pressure Stroke  Blackouts Diabetes- Type 1 or 2 High Cholesterol Tuberculosis  Blindness Ear Infections Hypoglycemia Traumatic Injury/MVA  Blood Clot(s) Endometriosis Menopause Weight Loss (unexplained)  Bowel/Bladder Problems Fibrords Major Spinal Injury  Chest/Abdominal Surgery Fractures MRSA Are you  Pregnant?  COPD/Emphysema Frequent Falls* Osteoporosis Pregnant?  Coronary Artery Disease Hearing Problems Pacemaker/Nitroglycerin Y N  Do you use tobacco products? Y N If yes, how much? For how long?  List current MEDICATIONS:  List current ALLERGIES:  List all SURGERIES:  |  |                               | -   |  | -                         |
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| 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   | _                                      |                               |   | <del>-</del>   |                           |
| MEDICAL HISTORY – Check any that apply  Angina/Chest Pain  |  | _                             | -   |  | _                         |
| Angina/Chest Pain  |  |                               |   |  |                           |
| Angina/Chest Pain  | What goals do you hope                 | to accomplish with Physical ' | Therapy?                                      |  |                           |
| Angina/Chest Pain  | AEDICAL HISTORY Chad                   | cany that apply               |   |  |                           |
| Asthma   |  |                               | Heart Disease                                 | Poor Circulation/Paymand's                                 | Other-                    |
| Are you  |  | _                             | •   | •  | Other-                    |
| Blackouts  |  | •                             | •   | •  |                           |
| Blindness   Ear Infections   Hypoglycemia   Traumatic Injury/MVA   Blood Clot(s)   Endometriosis   Menopause   Weight Loss (unexplained)   Bowel/Bladder Problems   Fibroids   Migraine Headaches   Whiplash   Carpal Tunnel Syndrome   Fibromyalgia   Major Spinal Injury   Chest/Abdominal Surgery   Fractures   MRSA   Are you   COPD/Emphysema   Frequent Falls*   Osteoporosis   Pregnant?   Coronary Artery Disease   Hearing Problems   Pacemaker/Nitroglycerin   Y N   N    *Have you had 2 or more falls in the past 12 months?   Y N   N   For how long?   List current MEDICATIONS:   List current ALLERGIES:   List all SURGERIES:   List SURGERIES:   |  | •                             | =   | _  |                           |
| Blood Clot(s)  |  | •                             | <b>0</b> •                                    | _  |                           |
| Carpal Tunnel Syndrome   Fibromyalgia   Major Spinal Injury   Chest/Abdominal Surgery   Fractures   MRSA   Are you   COPD/Emphysema   Frequent Falls*   Osteoporosis   Pregnant?   Coronary Artery Disease   Hearing Problems   Pacemaker/Nitroglycerin   Y   N   N   The you had 2 or more falls in the past 12 months?   Y   N   N   N   The you use tobacco products?   Y   N   If yes, how much?   For how long?   List current MEDICATIONS:   List current ALLERGIES:   List all SURGERIES:   List all SURGERIES:   List all SURGERIES:   List current metallic and surgery   Spinal Injury   Are you   Are you   Are you   Are you   Pregnant?   N   N   N   N   N   N   N   N   N   | Blood Clot(s)                          | _                             | •   |  |                           |
| Chest/Abdominal Surgery Fractures  | Bowel/Bladder Problems                 | Fibroids                      | =   | _  |                           |
| COPD/Emphysema   | Carpal Tunnel Syndrome                 | Fibromyalgia                  | Major Spinal Injury                           |  |                           |
| *Have you had 2 or more falls in the past 12 months? Y N  Do you use tobacco products? Y N If yes, how much? For how long?  List current MEDICATIONS:  List current ALLERGIES:  List all SURGERIES:  | Chest/Abdominal Surgery                | ○Fractures                    | ○MRSA   |  | Are you                   |
| *Have you had 2 or more falls in the past 12 months?  \( \) Y \( \) N  Do you use tobacco products? \( \) Y \( \) N \( \) If yes, how much? \( \) For how long? \( \)  List current MEDICATIONS: \( \)  List current ALLERGIES: \( \)  List all SURGERIES: \( \)   | COPD/Emphysema                         | ○Frequent Falls*              | Osteoporosis                                  |  | Pregnant?                 |
| Do you use tobacco products?  \( \)  | Coronary Artery Disease                | OHearing Problems             | Pacemaker/Nitroglyce                          | erin   | $\bigcirc$ Y $\bigcirc$ N |
| List current MEDICATIONS:  List current ALLERGIES:  List all SURGERIES:  | *Have you had 2 or mo                  | ore falls in the past 12 mor  | nths? OY ON                                   |  |                           |
| List current MEDICATIONS:  List current ALLERGIES:  List all SURGERIES:  | Do you use tobacco prod                | ucts? OY ON If yes,           | how much?                                     | For how long?  |                           |
| List current ALLERGIES: List all SURGERIES:  |  |                               |   |  |                           |
| List all SURGERIES:  |  |                               |   |  |                           |
|  |  |                               |   |  |                           |
|  |  |                               |   | <u> </u>   | undated 2/17/2021         |