Centralia • Chehalis
Physical Therapy

MEDICAL QUESTIONNAIRE

Name_________________________________ DOB___________ Age_____ Height_______ Weight________

Occupation__________________________ How did you hear about our clinic?______________________________

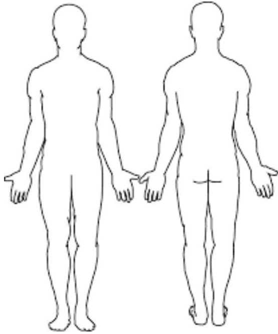
What problem/issue brings you here today? ____

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 ◯ 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-active/remission	◯Heart Disease	◯Poor Circulation/Raynaud's	◯Other-
◯Asthma	◯History of Covid-19	◯Hepatitis	◯Seizures	__________
◯Arthritis	◯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	◯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

*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:____

Signature_________________________________ **Date**___________________

updated 2/17/2021