Centralia • Chehalis • Grand Mound • Castle Rock

**Physical Therapy**

# MEDICAL QUESTIONNAIRE

Name: DOB: Age: Height: Weight:

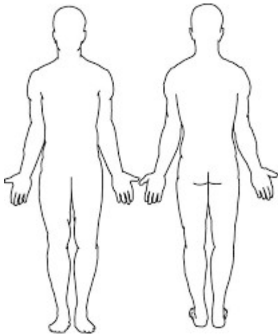
Occupation: What problem/issue brings you here today?

Side of Injury: Right Left *Date of Injury/Surgery/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? Y N 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 |
| Asthma | History of Covid-19 | Hepatitis | Seizures |
| Arthritis | Depression | High Blood Pressure High | Stroke |
| Blackouts | Diabetes- Type 1 or 2 | 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 | Other: |
| Chest/Abdominal Surgery | Fractures | MRSA | |
| COPD/Emphysema | Frequent Falls* | Osteoporosis | |
| Cronary Artery Disease | Hearing Problems | Pacemaker/Nitroglycerin | |

Are you pregnant? 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