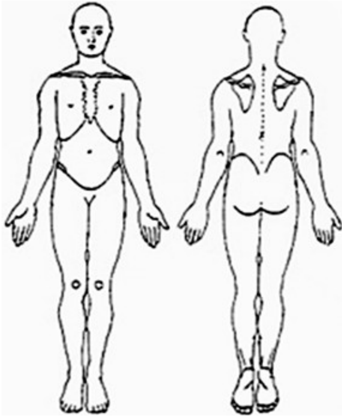
SQUAK MOUNTAIN PHYSICAL THERAPY MEDICAL QUESTIONNAIRE

Patient Name ____ Date_________________
Date of Birth _______________ Age ________ Occupation ______________________________________
Please briefly describe your symptoms and how your injury or condition occurred:___________________
____
____



← *Please mark areas of pain or discomfort on the figures to the left.*

Please rate your pain level below. Scale: 0= no pain, 10= highest level of 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

Frequency of pain: □ Constant □Intermittent

Does the pain wake you at night? □ Y □ N If yes, 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 on □Light Duty □ Normal Duty
Current level of physical activity? □High □Medium □Low List:_____________________________________
What activities at home, work or recreational are you unable to perform?______________________________
Have you had a similar condition before? □Yes □No If yes, when ___________________________________
Have you had tests for this condition? □Yes □No If yes, results _________________________________
What type? □X-Rays □MRI □Bone Scan □CT Scan □Nerve Tests □Blood Tests □Other ________
Have you had other treatment for this condition? □Y □N □PT □OT □LMT □LAC □Chiro
Have you had surgery for this condition? □Y □ N If so, when? _____________________________________
When is your next appointment with your primary care physician? _______________________________
What goals would you like to accomplish with physical therapy? ___________________________________

MEDICAL HISTORY (mark all that apply)

□Angina/Chest Pain
□Asthma
□Arthritis
□Blackouts
□Back/Neck Pain
□Blood Clots
□Bowel or Bladder Issues
□Cancer
□Chest/Abdominal Surgery
□Coronary Artery Disease
□Emotional/Psychological
□Ear Infections
□Fibromyalgia
□Fractures
□Frequent Falls
□Hearing Problems
□Heart Disease
□Hepatitis
□High Blood Pressure
□High Cholesterol
□Hypoglycemia
□Menopause
□Migraines
□MRSA
□Traumatic Injury
□Pacemaker
□Poor Circulation
□Polio
□Seizures
□Shortness of Breath
□Sleeping Problems
□Stroke
□TB
□Vision Problems
□Whiplash
□Other _________________

Are you pregnant? □Y □N

Tobacco User? □Y □N

Current Medications:____
Allergies: ____
Surgeries____

Signature: ____ Date: ______________