SPT
SOUTHEASTERN
PHYSICAL THERAPY

MEDICAL HISTORY QUESTIONNAIRE

Please Print

Name:________________________ DOB:______________ Age:_______ Date:______________

Referring Physician: ____

Reason for Visit: ____

When did this injury/problem occur? ____

If you are experiencing pain, HOW did it occur? ____

What difficulties are you having with this injury? ____

What positions/activities improve your symptoms? ____

____

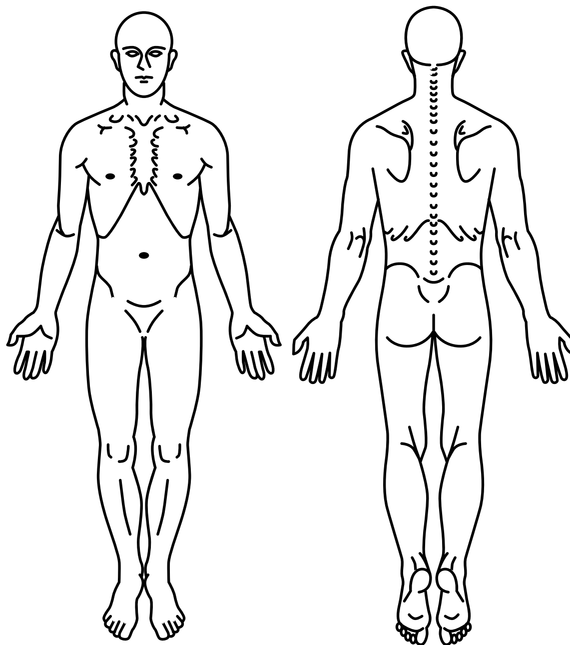
What positions/activities make your symptoms worse? ____

____

Are your symptoms: ❑ getting worse ❑ improving ❑ the same

PAIN DIAGRAM

Please use the following diagram below to indicate where you feel your symptoms currently.
Use the key below to indicate the different types of symptoms.



KEY

Pins & Needles = 00000

Stabbing = /////

Burning = XXXXX

Deep Ache = zzzzz

Please rate your pain using the following scale:

0	1	2	3	4	5	6	7	8	9	10

(no pain) (worst Imaginable pain)

Today: _____/10 **At Best: _____/10** **At Worst: _____/10**

Name: ____ DOB: ________________

CURRENT CONDITIONS/SYMPTOMS:

(please check all that apply)

- ❑ Nausea/Vomiting
- ❑ Pregnancy
- ❑ Fainting
- ❑ Dizziness
- ❑ Headaches
- ❑ Fatigue
- ❑ Fever/Chills/Sweating
- ❑ Pain at night
- ❑ Unexplained weight change
- ❑ Shortness of breath

What medications are you currently taking? ____

____

Please check and date any pertinent diagnostic test:

❑ x-ray: __________ ❑ MRI: __________ ❑ Bone Scan: __________ ❑ Other: __________

Please list any previous treatment(s) you've had for this condition: ______________________________

____

Do you have a problem with: ❑ speech ❑ vision ❑ hearing ❑ communication

PAST MEDICAL HISTORY:

(please check all that apply)

- ❑ **No Significant History**
- ❑ Alzheimer's Disease
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood Clots
- ❑ Bowel/Bladder Problems
- ❑ Cancer
- ❑ Circulatory Disease
- ❑ Depression/Anxiety
- ❑ Diabetes
- ❑ DVT (blood clot)
- ❑ Eating Disorder
- ❑ Emphysema/Bronchitis (COPD)
- ❑ Epilepsy
- ❑ Gout
- ❑ Heart Attack
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Latex Allergy
- ❑ Multiple Sclerosis
- ❑ Osteoporosis
- ❑ Pacemaker/Metal/Other Implants
- ❑ Psychological Disorder
- ❑ Rheumatoid Arthritis
- ❑ Scoliosis
- ❑ Sexual Dysfunction
- ❑ Sleep Apnea
- ❑ Stroke
- ❑ Substance Abuse Problem
- ❑ Thyroid Problems
- ❑ Tuberculosis

FAMILY MEDICAL HISTORY:

- ❑ Unknown
- ❑ No significant history
- ❑ Arthritis
- ❑ Cancer ________________
- ❑ Diabetes
- ❑ Heart Disease
- ❑ Other ______________

  ____

  ____

Please list any prior injuries/surgeries: ____

____

SOCIAL HISTORY:

Please list your leisure/fitness activities: ____

Date of last physical: ______________ Do you use tobacco? ❑ yes ❑ no Do you drink alcohol? ❑ yes ❑ no

What is your employment status?

Full Duty Restricted Duty Temporary Leave Retired (date_____) Disabled (date_____) Unemployed

Your goals for therapy: ____

____