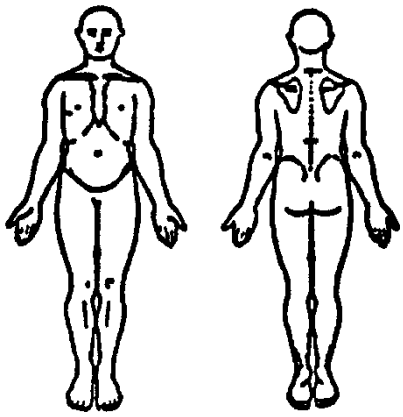
SOUND PHYSICAL THERAPY

MEDICAL HISTORY QUESTIONNAIRE

The information you give us here helps us provide you with better care.

Please mark on the drawing where you are feeling your pain or other symptoms.

Pain: circle area Numbness: /////
Pins/needles : :::::: Shooting pain: draw arrow



Please describe your pain - is it sharp, aching, burning?
Constant or intermittent?

_____
_____
_____
_____

On what date did injury / symptoms begin? _____ Date of surgery (if applicable) _____

How did your injury occur/symptoms begin? _____
_____
_____

Please rate your pain for each body part you are seeking care for on a scale from zero to 10, zero being no pain and 10 the worst pain you can imagine.

Body part: _____Your pain today____ The best it has been ____ The worst _____

Body part: _____Your pain today____ The best it has been ____ The worst _____

Body part: _____Your pain today____ The best it has been ____ The worst _____

What makes your symptoms Better? _____
Worse? _____

Have you had this problem or been injured in the same area before?_____
_____
_____

MEDICAL HISTORY QUESTIONNAIRE (page 2)

Referring Physician /date of last exam: _____ / _____

Primary Care Physician / date of last exam: _____ / _____

Have you ever felt hopeless or as if life was not worth living? ○yes/ ○no

If yes – in the past week or month? ○yes/ ○no/ ○na

For Women: (please check)
I have had a☐pelvic exam /☐breast exam/☐ mammogram in the past year.
I☐ am /☐ may be / ☐am not pregnant.
History of ☐endometriosis / ☐fibroids / ☐other uterine problems

For Men: (please check) I have had a prostate exam in the past year ○yes /○no

MEDICATIONS:
Please check if you are currently taking any of the following medications:

☐steroids ☐anti-inflammatories (ex: Aleve, Advil, ibuprofen) ☐pain meds (including Tylenol) Other:

☐muscle relaxants ☐anti-coagulants (blood thinners) ☐diabetes meds

☐blood pressure meds ☐heart medication

Personal medical history (check any that apply):

☐Cancer/ tumors
☐Osteoporosis
☐Arthritis
☐Asthma
☐Shortness of breath
☐Heart trouble/angina
☐Coronary artery disease
☐Pacemaker/nitroglycerin patch
☐ Dizziness
☐ Epilepsy/seizures
☐ Blackouts
☐ Frequent falls
☐ Severe night pain
☐ Night sweats
☐ Recent/sudden weight changes
☐ Diabetes
Surgery to: ☐chest /☐abdomen/ ☐pelvic region / ☐colon
☐ Poor circulation
☐ Easy bruising
☐ Loss of hearing
☐ Thyroid problems
☐ Bladder problems
☐ Smoking
☐ Headaches

ALLERGIES? Medications, Foods, Latex, Tape, Bees, Etc: Please list the reactions you have had:_____

PRIOR SURGERIES:_____

IMAGING: XRAYS/ MRI/ CT Scan: When? What body part? Results?_____

_____

_____ _____
PATIENT SIGNATURE **DATE**

Print

SOUND PHYSICAL THERAPY

FUNCTIONAL SURVEY

WHAT ARE YOUR GOALS FOR RECOVERY?:_____

_____

MARK YOUR **CURRENT STATUS** IN THESE CATEGORIES

WALKING TOLERANCE
- ☐ No pain with walking
- ☐ Can walk as much as I like but with increased pain
- ☐ Can walk 1 mile
- ☐ Pain walking hills
- ☐ Can walk < ¼ mile
- ☐ Leg symptoms with walking

SLEEP DISTURBANCE
- ☐ No disrupted sleep
- ☐ No disturbance, but increased pain upon awakening
- ☐ Difficulty getting to sleep due to pain
- ☐ Sleep disturbed 2-3 hours/night
- ☐ Sleep disturbed < 1 hour per night
- ☐ Arm/hand numbness with sleeping

STAIRS
- ☐ No pain with stairs
- ☐ Unable to climb more than 1 flight of stairs
- ☐ Pain/instability stepping on/off curb
- ☐ More pain up stairs
- ☐ More pain descending stairs

DRIVING
- ☐ No pain with driving
- ☐ Can drive as long as I want, but increased pain
- ☐ Can drive < 30 minutes
- ☐ Pain whenever I drive

WORK STATUS

Occupation _____

Work Duties _____

_____

Working: Full time ☐ Part time ☐
Light Duty ☐ Not working ☐
- ☐ No pain with work duties
- ☐ Can work as much as I like but with increased pain
- ☐ Modifying work due to pain
- ☐ Not working due to pain

SITTING TOLERANCE
- ☐ No pain with sitting
- ☐ Can sit as long as like but with increased pain
- ☐ Time depends on chair
- ☐ Pain with sitting < 5 minutes
- ☐ Leg symptoms with sitting

STANDING TOLERANCE
- ☐ No pain with standing
- ☐ Pain with stand > 1 hour
- ☐ Pain with stand < 15 minutes
- ☐ Pain with standing at sink/counter
- ☐ Pain standing after prolonged sitting

LIFTING TOLERANCE
- ☐ No pain with lifting
- ☐ Can lift but with pain
- ☐ Can only lift light weight
- ☐ Cannot lift at all
- ☐ Squatting: pain with squatting ☐
  noise with squatting ☐

REACHING & BENDING
- ☐ No pain with reaching
- ☐ Pain reaching overhead
- ☐ Pain reaching behind back
- ☐ Pain reaching across body
- ☐ Pain when bending over
- ☐ Pain when twisting and leaning back

OTHER ACTVITIES

Can you perform your normal home and fitness activities:

_____

Usual sport/recreational activities

_____

What are you currently able to do?_____

_____

Regular cardio-vascular or walking program?

_____

How many times a week? _____

Gym Program and how many times a week?

_____

Pain with housework? _____

Pain with yardwork? _____

raking ☐ shoveling ☐ mowing ☐ weeding ☐ planting ☐

Print Form