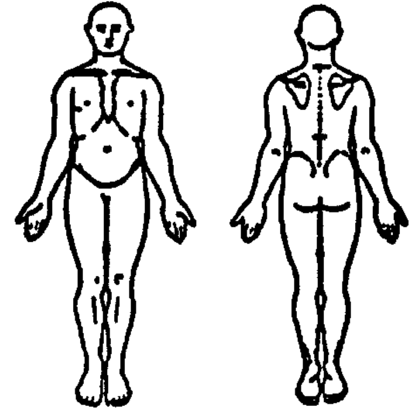
SOUND
PHYSICAL THERAPY

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 _____

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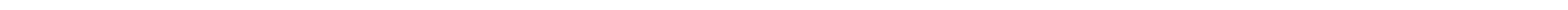
What makes your symptoms Better? ______________________________
Worse? ______________________________

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

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