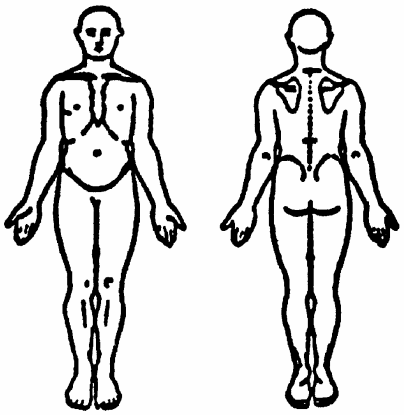
SOUND PHYSICAL THERAPY

MEDICAL HISTORY QUESTIONNAIRE

Please mark on the drawing, using the following symptoms, where you are feeling your pain or other symptoms (this first section should be marked by hand after printing form).

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



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

When did injury occur? _____
When did your symptoms begin?_____

How did your injury occur/symptoms begin?

Please rate your pain on a scale from zero to 10 with zero being no pain and 10 the worst pain you can imagine for all three times described below:
Your pain today_____ The best it has been _____ The worst it has been_____

What makes your symptoms Better? _____
Worse? _____

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

Can you perform your normal home and work activities?_____

MEDICAL HISTORY QUESTIONNAIRE

Referring Physician/date of last exam:_____

Primary Care Physician/date of last exam:_____

For Women: (please check) I have had a ☐ Pelvic exam/ ☐ breast exam/ ☐ mammogram ☐ in the past year …… … ☐ I am/ may be pregnant

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

MEDICATIONS:
Please check if you take any of the following medications:

☐ Steroids	☐ anti-inflammatory (including aspirin)	☐ Pain killers (including Tylenol)
☐ Muscle relaxants	☐ anti-coagulants (blood thinners)	☐ insulin (or other diabetes medication)
☐ Blood pressure medication	☐ Heart medication	Other:

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	☐ Chest/abdominal or pelvic surgery

ALLERGIES? MEDICATION, FOODS, LATEX, TAPE, BEES, ETC: PLEASE LIST REACTIONS YOU HAVE HAD_____

PRIOR SURGERIES:_____

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

_____ _____

PATIENT SIGNATURE **DATE**

Print Form