PATIENT MEDICAL HISTORY QUESTIONNAIRE

To help your therapist better evaluate your condition please complete this form to the best of your knowledge. If you have any questions, please ask for assistance. Thank you.

PATIENT INFORMATION				
Today's Date:	First Name:	Middle Name/Initial:	Last Name:	
Nickname:	Gender: ☐ Male ☐ Female	Date of Birth:	Student: ☐ Full ☐ Part ☐ Not a Student	
Cell Phone Number:			Social Security Number:	
Occupation:				
Employer:			Employer Phone #:	
***Email:**				
Mailing Address:		City:	State:	Zip Code:
If patient is a minor, name of parent or guardian:			Parent/Guardian Phone Number:	
Emergency Contact Name:		Emergency Contact Phone Number:		
Referring Doctor:		Primary Care Physician:		
Date of Injury:		Injury Area:		
Date of Surgery:		Surgical Area:		
Describe How the Injury Occurred:				
Have you seen another physical therapist any time during this current year? ☐ Yes ☐ No If yes, where and whom:				
How did you find out about us? ☐ Internet ☐ Word of Mouth ☐ Doctor ☐ Other: _____				

RESPONSIBLE PARTY			
Last Name:	First Name:		Middle Initial:
Date of Birth:	*Email:		
Responsible Party's Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____			
Mailing Address:	City:	State:	Zip Code:
Cell Phone Number:	Social Security Number:		

MEDICAL HISTORY

(Please check any condition that you have a history of. Items not checked are understood to be negative.)

PATIENT	FAMILY		PATIENT	FAMILY	
☐	☐	Diabetes	☐	☐	High Blood Pressure
☐	☐	Heart Disease	☐	☐	Epilepsy
☐	☐	Arthritis	☐	☐	Blood disorders
☐	☐	Asthma/Emphysema	☐	☐	Severe Infections
☐	☐	Cancer	☐	☐	Migraines
☐	☐	Depression	☐	☐	DVT/Blood Clots
☐	☐	Stroke	☐	☐	Other _____

Please answer the following:

Do you have a history of fractures? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No

Do you have any metal implants? ☐ Yes ☐ No

Do you have any numbness or tingling? ☐ Yes ☐ No

Do you have a pace maker? ☐ Yes ☐ No

Please list the following

Surgeries that you have had: _____

Known allergies: _____

Medications you are currently taking_____

Prior orthopedic injuries: _____

Signature: _____Date: _____

If Under 18, Parent or Guardian Signature: _____ Date: _____