



### 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.

<b>PATIENT INFORMATION</b>			
Today's Date:	First Name:	Middle Name/Initial:	Last Name:
Nickname:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Student: <input type="checkbox"/> Full <input type="checkbox"/> Part <input type="checkbox"/> Not a Student
Cell Phone Number:		Home Phone Number:	
*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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where and whom:			
How did you find out about us? <input type="checkbox"/> Internet <input type="checkbox"/> Word of Mouth <input type="checkbox"/> Doctor <input type="checkbox"/> Other: _____			
<b>RESPONSIBLE PARTY</b>			
Last Name:		First Name:	Middle Initial:
Date of Birth:		*Email:	
Responsible Party's Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____			
Mailing Address:		City:	State:      Zip Code:
Cell Phone Number:		Home Phone:	
Employer:		Employer Phone #:	

## INSURANCE INFORMATION

### **Primary Insurance**

Insured's Last Name:		First Name:	Middle Initial:	SSN:
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone Number:	Patient's Relationship to Insured: Self Spouse Child Parent Other	
Primary Insurance Company Name:		Policy #:	Group #:	

### **Secondary Insurance**

Insured's Last Name:		First Name:	Middle Initial:	SSN:
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone Number:	Patient's Relationship to Insured: Self Spouse Child Parent Other	
Secondary Insurance Company Name:		Policy #:	Group #:	

## MEDICAL HISTORY

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

PATIENT	FAMILY		PATIENT	FAMILY	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Blood disorders
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Severe Infections
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Migraines
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	DVT/Blood Clots
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

**Please answer the following:**

Do you have a history of fractures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any metal implants?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any numbness or tingling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a pace maker?	<input type="checkbox"/> Yes <input type="checkbox"/> 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: \_\_\_\_\_