Physical Therapy Medical History Questionnaire and Consent to Treat

Name: ______________________ DOB: ______________ Date: __________
Referring Doctor: ______________________ Primary Insurance: __________
Occupation, including activities required during the day: ______________________
Leisure Activities/Exercise: ______________________
Pregnant: Y N Due Date: __________ Smoker: Y N
Do you have a pacemaker: Y N Allergies: ______________________
Emergency Contact (name/phone): ______________________ Relation: __________

Past Medical History: (check if you EVER have been told you have/had)

- ☐ Arthritis
- ☐ Head injury
- ☐ Ulcers
- ☐ Osteoporosis/osteopenia
- ☐ Cancer
- ☐ Stroke
- ☐ Pacemaker
- ☐ Depression
- ☐ Seizures
- ☐ Diabetes
- ☐ Digestive problems
- ☐ Mental illness
- ☐ Heart problems
- ☐ Lung problems
- ☐ Kidney disease
- ☐ Liver disease
- ☐ High blood pressure
- ☐ Parkinson's disease
- ☐ Chemical dependency
- ☐ Broken bones: __________
- ☐ Other: __________

Current Medications (prescription and non-prescription): (☐ See Attached Sheet) ______________________
____

Have you ever taken steroid medication for any medical condition? Yes No
Have you ever taken blood thinners or anticoagulant medication? Yes No

Since your symptoms began, have you had any of the following:

- ☐ Dizziness
- ☐ Fever/sweat/chills
- ☐ Loss of balance
- ☐ Weight changes
- ☐ Nausea/ vomiting
- ☐ Numbness/tingling/burning
- ☐ Numbness in genital/anal area
- ☐ Significant night pain
- ☐ Bowel/bladder changes
- ☐ Weakness
- ☐ Fatigue
- ☐ Recent infection
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Increased headaches
- ☐ Problems with vision/hearing/speech
- ☐ Other: __________

Family Medical History: (immediate family members)

- ☐ Cancer
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Blood Clots
- ☐ Stroke

During the past month have you been bothered by feeling down, depressed or hopeless? Yes No
During the past month have you often been bothered by little interest or pleasure in doing things? Yes No
Is this something with which you would like help? Yes No Yes, but not today

Current Symptoms:

What do you believe started the symptoms? ______________________
When (approximately) did the symptoms start? ______________________
Are the symptoms getting: ☐ WORSE ☐ BETTER ☐ STAYING THE SAME
Have you received any treatment for your current symptoms? Yes No
If Yes, what and was it helpful? ______________________
Any surgeries, hospitalizations, or imaging (x-ray, MRI)? ______________________
How are you able to sleep at night? ☐ No problem sleeping ☐ Wake with pain ☐ Difficulty falling asleep ☐ Only with medication

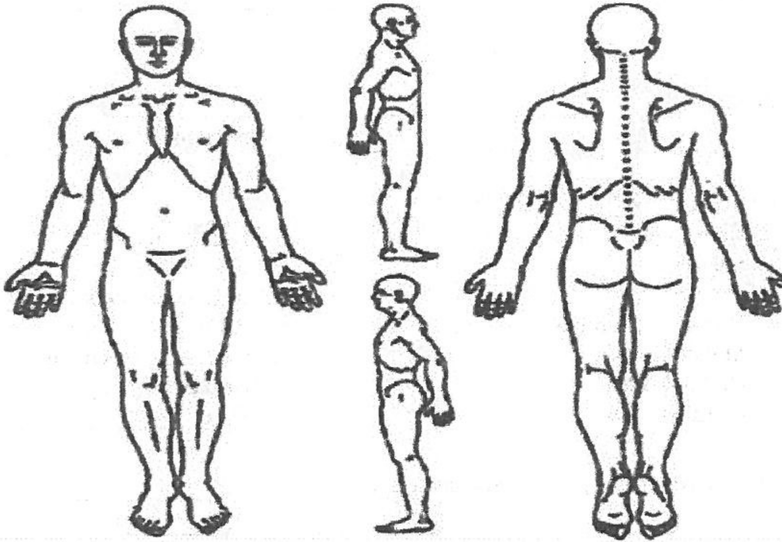
Please describe the nature of your primary complaint: ____________________
(i.e. pain, numbness, tingling, weakness)

Please use the scales below to describe the severity of your pain:

Worst level of pain: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

Current level of pain: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

Best level of pain: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible



Please mark the areas that you feel pain

When during the day are your symptoms better?
____

When during the day are your symptoms worse?
____

Aggravating Factors: Please list 3 activities that make your symptoms worse:

1. ____________________
2. ____________________
3. ____________________

Easing Factors: Please list 3 activities that make your symptoms better:

1. ____________________ 2. ____________________ 3. ____________________

What are your goals for physical therapy? ____________________

Additional Notes:

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Patient Signature: ____________________ Date: __________
Therapist Signature: ____________________ Date: __________