DuPont Physical Therapy

MEDICAL QUESTIONNAIRE

Medical Questionnaire

Patient Name:_______________________ Date_____________ Date of Birth_____________ Age_____

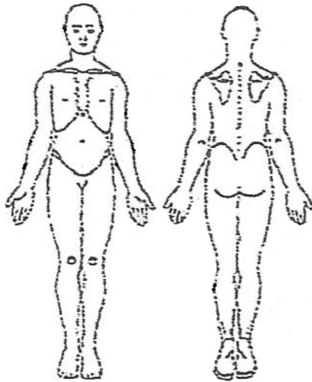
Occupation:_______________________ Employer:_______________________ Hrs/Wk__________

What problem or diagnosis brings you here today?_______________________

Side of Injury: ○ R ○ L Date of Injury?_____________ Who referred you to PT?_______________________

Briefly describe your symptoms:_______________________

Describe how your condition or injury occurred:_______________________



Shade your areas of pain or discomfort on the figures to the left:

Please rate your pain on the scale below from 0 to 10:
(0=no pain; 10=worst pain imaginable/emergency room pain)

Pain at rest: ○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

Pain with activity: ○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

What is the frequency of your pain? ○ Constant ○ Intermittent

Does your pain wake you at night? ○ Y ○ N

How many times?_____________________

What eases your symptoms?_______________________

What aggravates your symptoms?_______________________

Are your symptoms getting ○ Better ○ Worse ○ Same Is your pain worse in the ○ AM ○ PM ○ Mid-Day

Are you currently working? ○ Y ○ N Are you currently on: ○ Light duty ○ Normal Duty

Is this a Motor Vehicle claim? ○ Y ○ N

What activities at home, work or recreational are you unable to perform?_______________________

Have you had a similar condition before? ○ Y ○ N If yes, when_______________________

Have you had tests for this condition? ○ Y ○ N If yes, results:_______________________

CIRCLE tests: X-Rays MRI Bone Scan CT Scan Nerve Tests Blood Tests Other_______________________

Have you had any other treatment for this condition? ○ Y ○ N

If yes, what Kind? ○ PT ○ OT ○ Chiropractic ○ Massage

CIRCLE Current Level of Physical Activity: ○ High ○ Medium ○ Low List:_______________________

What goals do you hope to accomplish with Physical Therapy?_______________________

Medical History (Check all that apply)

☐ Angina/Chest Pain	☐ Cancer	☐ Hearing Problems	☐ Osteoporosis
☐ Asthma	☐ Depression	☐ Heart Disease	☐ Pacemaker/Nitroglycerin
☐ Arthritis	☐ Diabetes	☐ Hepatitis	☐ Poor Circulation/Raynaud's
☐ Blackouts	☐ Diverticulitis	☐ High Blood Pressure	☐ Polio
☐ Blindness	☐ Ear Infections	☐ High Cholesterol	☐ Seizures
☐ Blood Clot	☐ Endometriosis	☐ Hypoglycemia	☐ Stroke
☐ Bowel or Bladder Problems	☐ Fibroids	☐ Menopause	☐ TB
☐ Carpel Tunnel Syndrome	☐ Fibromyalgia	☐ Migraine Headaches	☐ Traumatic Injury/MVA
☐ Chest/Abdominal Surgery	☐ Fractures	☐ Major spinal issues	☐ Other
☐ Coronary Artery Disease	☐ Frequent Falls	☐ MRSA	

Are you Pregnant? ○ Y ○ N

Do you have a history of whiplash or low back pain? ○ Y ○ N If so, when/how long?_______________________

Do you smoke tobacco? ○ Y ○ N If yes, how much?_________________ How long?_______________________

Medications/Allergies/Surgeries

List current medications:_______________________

List current allergies:_______________________

List all surgeries:_______________________

Signature_______________________ Date_________________