BODIES IN MOTION PHYSICAL THERAPY

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____ **DOB**_____ **DATE**_____

Age _____ Height _____ Weight _____ Occupation: _____

Physical Requirements of Job: _____

Current problem

- When did your pain start? (or surgery date) _____
- What goals do you hope to achieve from therapy? _____
  _____
  _____

Circle the number which represents the **worst** level of pain you have experienced over the past week:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Imaginable

Circle the number below which represents the **current** level of pain:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Imaginable

Circle the number below which represents the **least** level of pain you have experienced over the past week:

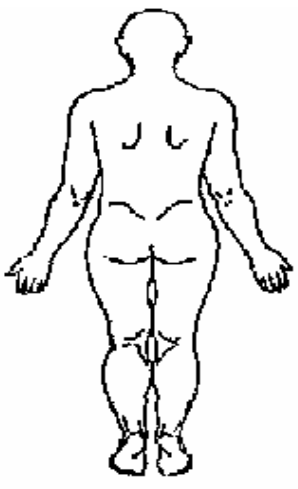
No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Imaginable

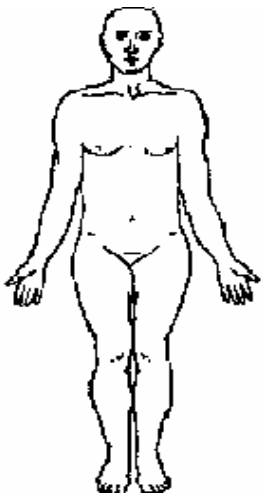
Circle the things that make your pain worse?

Sitting	Standing	Walking	Ascending Stairs	Descending Stairs
Sit to Stand	Bending	Voiding	Lying Down	Coughing/Sneezing

What do you do to help make the pain less? _____
_____
_____

Please mark on drawings where you feel your pain:





Any previous history of these symptoms? **YES / NO**

If yes, when? _____

What treatments have you received for this problem so far?

_____
_____
_____
_____

BODIES IN MOTION PHYSICAL THERAPY

MEDICAL HISTORY QUESTIONNAIRE

Any history of falls? **YES / NO** **PATIENT NAME:_____**

If yes, when? _____

Past Medical History: (circle all that apply)

Alzheimer's	Diabetes	Huntington's Disease	Osteoarthritis
Cardiovascular Disease	Fibromyalgia	Immunosuppression	Parkinson's
Bowel or Bladder Changes	Fracture	Lupus	Rheumatoid Arthritis
Stroke	High Blood Pressure	Muscular Dystrophy	Traumatic Brain Injury
Current Infection	History of Cancer	Obesity	Hepatitis

Have you had an x-ray, MRI, or other imaging study for this problem? **YES / NO**

List any other prior or current injuries, surgeries, illnesses or medical conditions (including prior episodes of back pain, knee pain, etc.) including time frames:

_____

_____

_____

Current Medications: Please include Over the Counter medications as well as Prescription medications

MEDICATION	DOSAGE

Currently I am experiencing: (circle all that apply)

Fever/Chills/Sweats	Poor Balance (Falls)	Unexplained Weight Loss	Numbness or Tingling
Change in Appetite	Difficulty Swallowing	Depression	Shortness of Breath
Dizziness	Headaches	Change in Bowel/Bladder Function	Nausea/Vomiting
Increased Pain at Night	Pain that **DOES NOT** change with activity	Pain that **DOES NOT** change with positioning	OTHER:

Are you a smoker? **YES / NO**

Do you exercise regularly? **YES / NO**

If yes, what do you do? _____

_____