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? _____
  _____
  _____

Check 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

Check 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

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

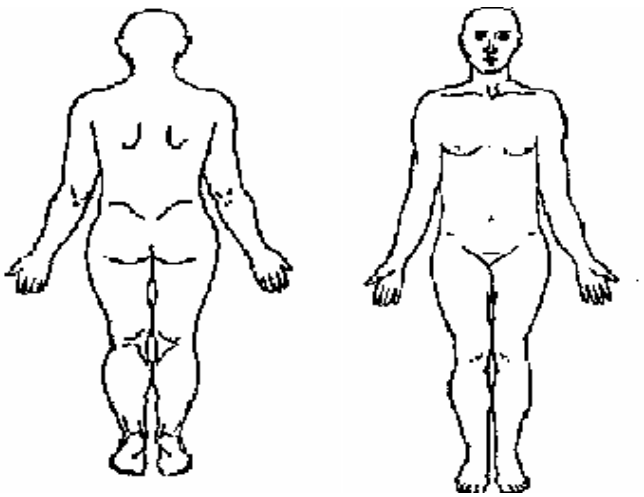
No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Imaginable

Check 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?
_____
_____
_____

Any History of falls? ___Yes ___No

If YES, when? _____

Past Medical History: (Check 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 **all** Over the Counter medications as well as Prescription Medications

MEDICATION	DOSAGE

Currently I am experiencing: (Check 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? _____

_____