PATIENT MEDICAL HISTORY AND INTAKE QUESTIONNAIRE

NAME: _____ AGE: _____ SEX: F __ M __ HEIGHT: _____ WEIGHT: _____ OCCUPATION: _____

Are you presently working? YES _____ NO _____ If No - Last Day Worked? _____

Referring Physician: _____ Primary Insurance: _____ Secondary: _____

Primary Care Physician: _____

Check if any of the following apply: _____ Work Related Injury _____ Motor Vehicle Accident _____ Personal Injury Claim

What is your main complaint and in what area is it located? _____

_____

Have you ever had these symptoms before? Yes _____ No _____ If Yes - When? _____

Have you had physical therapy, occupational therapy or chiropractic care for this injury before? Yes _____ No _____

Which one and when? _____

What have you been doing to decrease your pain? _____

On a scale from 0 (no pain) to 10 (very severe pain), what is your pain level: At Rest: _____ When Active: _____ At its Worst: _____

Circle any tests you have had for this diagnosis: NONE XRAYS MRI CT Scan Bone Scan Other: _____

Check any with which you have difficulty: _____ Housekeeping _____ Lifting _____ Driving _____ Shopping _____ Reaching _____ Dressing

_____ Climbing Stairs _____ Child Care _____ Bending _____ Yard Work _____ Sit to Stand

Are your symptoms getting worse, better, the same, since your injury? _____

Are you currently taking any medications? (Please list dosage and frequency) _____

_____

Do you have any allergies? (Please list) _____

Check any of the following conditions you have **ever had**:

- ☐ Arthritis
- ☐ Fractures
- ☐ Osteoporosis
- ☐ Blood Disorders
- ☐ Circulation Problems
- ☐ Heart Problems
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Lung Problems
- ☐ Stroke
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Head Injury
- ☐ Multiple Sclerosis
- ☐
- ☐ Muscular Dystrophy
- ☐ Parkinson Disease
- ☐ Seizures
- ☐ Allergies
- ☐ Developmental Problems
- ☐ Thyroid Problems
- ☐ Cancer
- ☐ Infectious Disease
- ☐ Kidney Problems
- ☐ Repeat Infections
- ☐ Ulcers/Stomach Problems
- ☐ Skin Diseases
- ☐ Depression
- ☐ Allergy to Cold or Heat
- ☐ Other: _____

Check any of the following conditions you have had in the **past year**:

- ☐ Chest Pain
- ☐ Heart Palpitations
- ☐ Cough
- ☐ Hoarseness
- ☐ Shortness of Breath
- ☐ Dizziness or Blackouts
- ☐ Coordination Problems
- ☐ Weakness in Arms or Legs
- ☐ Loss of Balance
- ☐ Difficulty Walking
- ☐ Joint Pain or Swelling
- ☐ Pain at Night
- ☐ Difficulty Sleeping
- ☐ Loss of Appetite
- ☐ Nausea/Vomiting
- ☐ Difficulty Swallowing
- ☐ Bowel Problems
- ☐ Weight Loss/Gain
- ☐ Urinary Problems
- ☐ Fevers/Chill/Sweats
- ☐ Headaches
- ☐ Hearing Problems
- ☐ Vision Problems
- ☐ Other: _____

If any, please explain: _____

List all surgeries (with dates): _____

_____

Is there any other information about your present health that we should know about? _____

Preferred contact: PHONE EMAIL

PATIENT SIGNATURE: _____ DATE: _____ _____