

# Physical Therapy Medical History Intake Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_ Family Doctor: \_\_\_\_\_

## Mechanism of injury

- How did your problem start? \_\_\_\_\_
- Was there a specific injury? Yes No If yes what happened? \_\_\_\_\_  
\_\_\_\_\_
- When did your problem start? \_\_\_\_\_

## Prior level of function

- **Previous** to this injury/ problem did you have any limitation with doing all your activities? Yes No  
If yes please list your past limitations \_\_\_\_\_
- Please list your main recreational activities \_\_\_\_\_  
\_\_\_\_\_
- Do you work outside of the home? Yes No If yes what do you do? \_\_\_\_\_  
\_\_\_\_\_

## Main complaint/ restriction

- Please describe your main complaint/ restrictions \_\_\_\_\_  
\_\_\_\_\_
- What makes your problem better? \_\_\_\_\_  
\_\_\_\_\_
- What makes your problem worse? \_\_\_\_\_  
\_\_\_\_\_

## Pain scale

Please circle the **lowest and highest** your pain has been in the last 2 weeks, also put an x for your **current** level of pain.

0 None	1 Just noticeable	2 Mild, in background	3	4 Moderate, bothersome	5	6 Severe, can't function	7	8 Excruciating, ER time	9	10 BURNING AT THE STAKE!!!!
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- Where is your pain? \_\_\_\_\_
- What type of pain do you have? Aching numbness pins and needles burning sharp/stabbing throbbing other  
\_\_\_\_\_

## Medical/ surgical history

- What medical testing and/or previous treatment have you had for this condition?  
\_\_\_\_\_

- Please indicate any condition for which you have been treated for currently or in the past

Heart Disease	Yes	No	Head Injury	Yes	No
Hypertension (high blood pressure)	Yes	No	Cancer/Leukemia	Yes	No
Diabetes (high sugar)	Yes	No	Infectious Diseases	Yes	No
DVT (blood clots)	Yes	No	Osteoporosis	Yes	No
Balance Problems/Frequent Falls	Yes	No	Thyroid Problems	Yes	No
Lung Problems	Yes	No	Circulatory Problems	Yes	No
Arthritis (Osteoarthritis/ Rheumatoid)	Yes	No	Seizures	Yes	No
Cervical Trauma/Whiplash	Yes	No	Stroke/TIA	Yes	No
Significant Trauma/ Illness	Yes	No	Gout	Yes	No

List any other medical problems that have not already been listed: \_\_\_\_\_  
\_\_\_\_\_

**Review of Systems**

- Please indicate any of the following which you are **currently** experiencing

Joint stiffness/swelling	Yes	No	Numbness/Tingling	Yes	No
ringing/buzzing in ears	Yes	No	Headaches	Yes	No
Visual changes	Yes	No	Heartburn	Yes	No
Chest pain	Yes	No	Shortness of breath	Yes	No
Persistent cough	Yes	No	Nausea/Vomiting	Yes	No
Abdominal pain/bloating	Yes	No	Depression	Yes	No
Metallic taste in mouth	Yes	No	Sore throat	Yes	No
Fever	Yes	No	Lack of appetite	Yes	No
Difficulty swallowing	Yes	No	Night sweats	Yes	No
Fainting	Yes	No	Increased urinary frequency	Yes	No
Urinary incontinence	Yes	No	Bowel dysfunction	Yes	No
Unexplained Weight loss/ gain	Yes	No	Pregnancy	Yes	No
Irregular or missed periods	Yes	No	Night Pain	Yes	No
Pain radiating down arm/leg	Yes	No			

- Please indicate any of the following, which you have experienced, that has affected your normal daily activity for 2 weeks or more

Weakness	Yes	No	Fatigue	Yes	No
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- Do you smoke? Yes No

**Medication:** Include prescription, over the counter medications and supplements. If you have a list we can copy it \_\_\_\_\_

**Allergies**

**Patient goal**

What is/are your main goals for physical therapy?

**Functional limitation**

- What activities are you currently unable to do? \_\_\_\_\_
- What activities are very difficult to do? \_\_\_\_\_
- What activities are moderately difficult to do? \_\_\_\_\_
- What activities are slightly difficult to do? \_\_\_\_\_

**Any other concerns you may have that we should be aware of?** \_\_\_\_\_

By signing below, I attest that I have personally reviewed the information on this sheet.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist signature: \_\_\_\_\_ Date: \_\_\_\_\_