MAC PHYSICAL THERAPY

Patient Questionnaire/Health History

Name: _____ Date: _____

History of Present Condition

1. What are your symptoms/chief complaints? _____

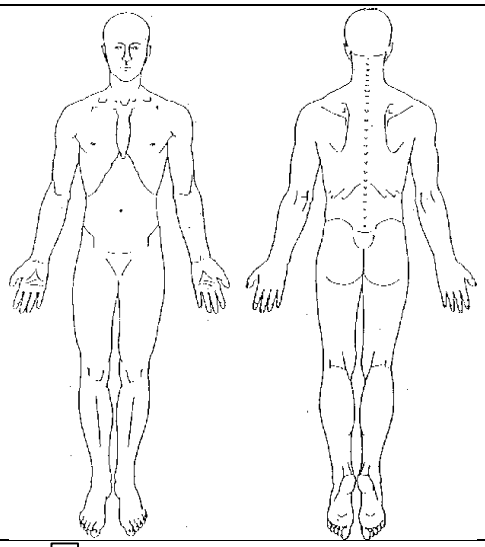
_____

2. When did your symptoms begin? *(Please indicate a specific date or surgery date if possible)*: _____

3. *0 being no pain at all, 10 being the worst pain imaginable,* please indicate your discomfort levels below:

Best: _____ Worst: _____ Now: _____

Localize areas of **discomfort** or **abnormal** sensation on the body chart below *(shade in where appropriate)*



4. Nature of discomfort/symptoms *(check all that apply)*

- ☐ Sharp ☐ Numbness ☐ Occasional
- ☐ Dull ☐ Tingling ☐ Constant
- ☐ Throbbing ☐ Aching ☐ Other: _____

5. Since onset, are your symptoms getting: *(check one)*

☐ Better ☐ Worse ☐ Not Changing

6. Please list any recent/relevant past surgeries.

_____

_____

_____

_____

7. Since the onset of your current symptoms have you had:

- ☐ Fever/Chills
- ☐ Weakness
- ☐ Numbness
- ☐ Night Pain/Sweats
- ☐ Difficulty with control of bowel or bladder function
- ☐ Dizziness or fainting attacks
- ☐ Unexplained weight change
- ☐ Numbness in the genital or anal area
- ☐ Malaise (vague feeling of bodily discomfort)
- ☐ Problems with vision/hearing
- ☐ Other: _____

_____

8. As the day progresses, do your symptoms: (*check one)* ☐ Increase ☐ Decrease ☐ Stay the same

9. Have you had any previous treatment for this condition?

- ☐ None
- ☐ Physical Therapy
- ☐ Massage Therapy
- ☐ Chiropractic
- ☐ Medication
- ☐ Injection
- ☐ Traction
- ☐ TENS Unit/ E-STIM
- ☐ Acupuncture
- ☐ Hospitalization
- ☐ Bracing/Taping/Casting
- ☐ Other:_____

_____

10. Have you had any of the following tests?

- ☐ None
- ☐ X-Rays
- ☐ CT Scan
- ☐ MRI
- ☐ Stress X-Ray Test
- ☐ Arthrogram
- ☐ Nerve Conduction Study
- ☐ Bone Scan
- ☐ EMG
- ☐ Other: _____

_____

11. Have you ever had/been diagnosed with any of the following conditions *(check all that apply)*

- ☐ Cancer (type): _____
- ☐ Depression
- ☐ Stroke
- ☐ Kidney problems
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Multiple sclerosis
- ☐ Arthritis
- ☐ Head injury
- ☐ Stomach problems
- ☐ Infectious diseases
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Lung problems
- ☐ Blood disorders
- ☐ Epilepsy/seizures
- ☐ Allergies
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Broken bone
- ☐ Circulation/vascular problems
- ☐ Other: _____

_____

Medication:

Please list any medications you are currently taking:

_____ _____ _____

_____ _____ _____

Goals for Physical Therapy:

_____

_____