ALLIANCE PHYSICAL THERAPY Patient Questionnaire/Medical History

I, _____ understand that my diagnosis and treatment plan will be discussed during my
(Print name)
appointment and that I have the right to question and/or refuse any treatment offered.

_____ _____
(Patient Signature, Parent sign if a minor) **(Date)**

Gender: M / F Age: _____ Smoker: Y / N Pregnant: Y / N

Occupation: _____ Height/Weight _____

Do you have any barriers to learning? Yes/No If "Yes", please list: _____

Do you exercise at least 3 days per week? Y / N

Reason for being seen today: _____ Body Part _____ L/R

What date (approximately) did your present pain start? _____

How (gradually, suddenly, injury)? _____

What treatment have you received for this problem so far? _____

Describe your pain: Sharp Dull Stabbing Throbbing Aching Burning Other:_____

What makes your symptoms better? _____

What makes your symptoms worse? _____

Have you had an x-ray, MRI, or other imaging study for this problem? Y / N

Please circle the number which best represents the average level of pain you have experience over the past 48 hours:

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

How are you able to sleep at night? ☐ Fine ☐ Moderate Difficulty ☐ Only with medication

What are your personal goals for Physical Therapy at this time? _____

_____

Currently, I am experiencing (circle all that apply):
Fever/chills/sweats Unexplained weight loss/gain Numbness/tingling Change in appetite
Difficulty swallowing Depression Dizziness Shortness of breath Headaches
Changes in bowel or bladder function Nausea/Vomiting Increases pain at night
Poor balance: Y / N
Have you had 2 or more falls in the past 12 months or any fall with an injury? Y / N

Medical History: ***Please circle each condition that you have been told you have (or had):***
Cancer Diabetes Kidney Disease/Stones Liver Disease Stroke
High Blood Pressure Heart Disease/Attack Angina/Chest Pain Fibromyalgia Ulcers
Migraines/headaches High Cholesterol Lung Disease/Emphysema Rheumatoid Arthritis Neuropathy
Osteoporosis Osteoarthritis Depression/Anxiety Asthma
Pacemaker Blood Clots/Clotting Disorder Sleep Apnea Thyroid
Sexually transmitted Disease Hepatitis A/B/C

Do you take blood thinners? Y / N
List any Allergies to Medications, etc: _____ _____ _____ _____
List current Medications & Supplements: _____ _____ _____
See attached sheet ☐
Past Surgical History: List & Dates _____ _____ _____
See attached sheet ☐