**Premier Physical Therapy Services Medical History/ Questionnaire** **Today's Date**_____
To Be Completed by the patient or guardian – Please Print

**Name**_____ **D.O.B.** _____ **Height/Weight:** _____

**Referring Physician:** _____ **Date of next physician's visit**: _____

**Chief Complaints: (What problems are you having?)**

_____

_____

**Date of injury/ when pain started?** _____ **Date of surgery (if applicable):** _____

**Have you had physical therapy or chiropractic treatment this year? Y N If yes, where:**_____

**Do you smoke? Y N If so, how many packs/day?**_____ **Do you drink alcohol? Y N How much?** _____

**Do you regularly exercise? Y N**

**Do you have any drug allergies: Y N Please specify** _____

**Please list your current medications: Additional pages are available at front desk**

| Name of Medication | Dosage | Directions | Date Stopped | Reason/ Doctor who prescribed |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Have you ever had the following (circle yes or no, leave blank if uncertain)**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Anemia | Y | N | Dizziness or Fainting Spells | Y | N | Pacemaker | Y | N |
| Arteriosclerosis | Y | N | Epilepsy | Y | N | Phlebitis | Y | N |
| Arthritis | Y | N | Gastrointestinal problems | Y | N | Pneumonia/Respiratory problems | Y | N |
| Asthma/Emphysema | Y | N | Heart disease | Y | N | Pregnant currently | Y | N |
| Back/Neck Trouble | Y | N | Hernia | Y | N | Skin Disease/Rashes | Y | N |
| Bleeding Tendency | Y | N | High or Low Blood Pressure | Y | N | Stroke | Y | N |
| Blood Clots | Y | N | Incontinence | Y | N | Thyroid Disease | Y | N |
| Cancer | Y | N | Kidney Disease | Y | N | | | |
| Circulatory Condition | Y | N | Metal Implants | Y | N | | | |
| Depression | Y | N | Migraines | Y | N | | | |
| Diabetes | Y | N | Mitral Valve Prolapse | Y | N | | | |

**If you answered yes to any of the items above, please briefly explain and give the date. Include pertinent information regarding your past medical history:**

_____

_____

**Previous surgeries (Please state the year and what illness/surgery you had)**

| **Date/Year** | **Illness/Operation** | **Date/Year** | **Illness/Operation** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Pain and Symptoms (Circle the best possible answer):

**Is your pain?** Occasional Continuous Constant Intermittent Unrelenting

**Symptom trend:** Condition improving Condition worsening Condition unchanging

**When is your pain the worst?** Morning Afternoon Evening Nighttime

**When is your pain the best?** Morning Afternoon Evening Nighttime

**Does the pain affect your sleep?** YES NO

**Circle the number the rates your pain *right now*:**

None 1 2 3 4 5 6 7 8 9 10 Go to the hospital

**Circle the number that rates your pain *at worst*:**

None 1 2 3 4 5 6 7 8 9 10 Go to the hospital

**Circle the number that rates your pain *at best*:**

None 1 2 3 4 5 6 7 8 9 10 Go to the hospital

**Please describe:**

**What makes your pain better?**

_____

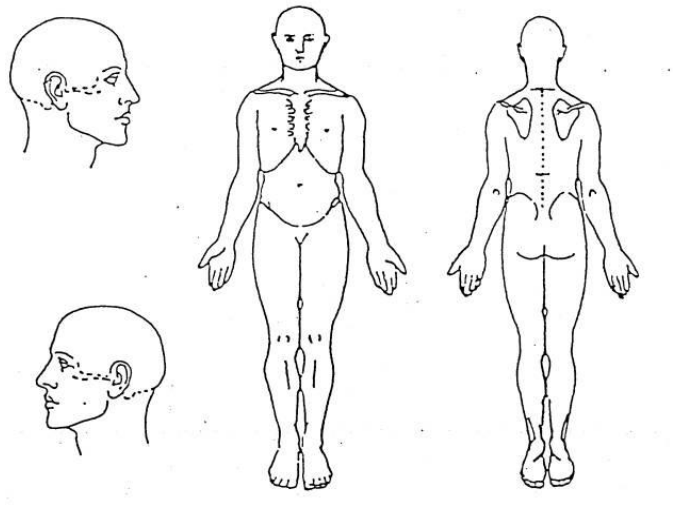
**What makes your pain worse?**

_____

**Due to my symptoms/disease I am unable to/have difficulty with _____**

**My goal(s) for therapy: _____**

**Please indicate below where your symptoms are located**



| **KEY** | |
|---|---|
| Numbness | = = = = = = |
| Pins & Needles | ******* |
| Burning Pain | BBBBBBB |
| Stabbing Pain | /////// |
| Shooting Pain | XXXXXXX |
| Achy Pain | AAAAAAA |

**My signature below confirms that this medical history is accurate to the best of my knowledge:**

_____ _____

**(Patient or guardian signature)** **(Date)** **rev. ANM 4/13**