ELEMENT PHYSICAL THERAPY
We are the balance experts

Patients Name ____________________ Date_____/___/______

Medical Questionnaire – Physical Therapy

Phone # (   ) ______________________ Occupation: ____

Reason for visit ____Have you had this condition before? ___________

Date of ☐ *Injury* - ☐ *Accident* (if applicable) _____/ _____/ ________ Date of 1st symptom _____/ _____/ ___________

If condition is work related:

Name of Employer: ____

Are you currently: ☐ *Unable to work* ☐ *On Light-Duty* ☐ *On Normal Duty*

Symptoms ____

If Injury/accident, where & how did it occur ____

Shade area(s) of pain or discomfort on the figures below & (if pain in more than one area) label w/#1 for area of greatest discomfort, #2, etc…

Please rate your pain (10 = worst pain imaginable) for:

Area #1

Describe any numbness or tingling _______________________________

Pain at rest: _____ Pain with activity ______

Frequency of pain? ☐ *Constant* ☐ *Intermittent* ☐ *Only with activity*

What eases your symptoms? _____________________________________

What aggravates your symptoms? ________________________________

Are symptoms getting: ☐ *Worse* ☐ *Better* ☐ *Same*

Does your pain wake you at night? ☐ *No* ☐ *Yes* - How often? ___________

Current level of physical condition: ☐ Low ☐ *Medium* ☐ *High*

Area #2, if different than above ____

____

____

Are there any home or recreational activities you are unable to perform? ____

____

Medical History *(Check all that apply)*

Current Height: _____' ______" Weight: ________ (any significant gain or loss in prev 12 mo.? ____________________

Tests done for this condition: ☐ *X-Rays*, ☐ *MRI*, ☐ *Bone Scan*, ☐ *CT Scan*, ☐ *Nerve Test*, ☐ *Blood*, ☐ *Other* __________________

____________________________________ _____/_____/_____
Patient Signature Date

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Patients Name ______________________ Date_____/___/______

Please mark all of the following with a:

- **"Y"** if you are currently experiencing or have a history of any of the following conditions
- Or mark with an **"N"** if you have never experienced the condition

☐ Blackouts
☐ Blindness
☐ Blood/Circulation Problem(s) ___________
☐ . . . . Clots
☐ . . . . Coronary/Peripheral Artery Disease
☐ . . . . High Blood Pressure
☐ . . . . Hyper/Hypoglycemia
☐ . . . . Poor Circulation/Raynaud's
☐ Bladder/Bowel Problem(s) _____________
☐ . . . . Diverticulitis
☐ . . . . Incontinence
☐ Breathing Problem(s) _________________
☐ . . . . Asthma
☐ . . . . COPD
☐ Cancer ______________________________
☐ Cardiac Problem(s) ___________________
☐ . . . . Angina/Chest Pain
☐ . . . . Congestive Heart Failure
☐ . . . . Heart Disease
☐ . . . . Pacemaker/Nitroglycerin

☐ Carpel Tunnel
☐ Depression
☐ Diabetes (type: 1 or 2) ________
☐ Ear Problem(s) ________________
☐ . . . . Hearing problems
☐ . . . . Vertigo/Dizziness
☐ Female Problem(s) _____________
☐ . . . . Endometriosis
☐ . . . . Fibroids
☐ . . . . Menopause
☐ . . . . Pregnant (possible pregnancy)
☐ Fibromyalgia
☐ Frequent Falls
☐
☐ Infection(s) __________________
☐ . . . . Hepatitis
☐ . . . . MRSA
☐ Major Spinal Injury
☐ Migraine Headaches
☐ Mood Disorder ________________

☐ Neurological Disorder __________
☐ . . . . MS
☐ . . . . Parkinson's Disease
☐ . . . . Peripheral Neuropathy
☐ . . . . Seizures
☐ Orthopedic Problem(s) __________
☐ . . . . Arthritis ________________
☐ . . . . Fracture/Broken bone/joint
☐ . . . . Osteoporosis
☐ . . . . Osteopenia
☐ Polio
☐ Stroke(s)
☐ TB
☐ Injury(s) ____________________
☐ . . . . Head Injury
☐ . . . . Motor Vehicle
☐ . . . . Traumatic
☐ . . . . Other:
☐ Other ________________________
____

Medications & Allergies

Current Medications	Dosage	Frequency	Route
Example: Asprin	200mg	3 times/day	by mouth

Allergies:
____
____

Surgical History:
____
____
____
____

________________________________ _____/_____/_____
Patient Signature Date

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