Injury and Past Medical History Questionnaire

Patient Name: _____ DOB: _____ Date: _____

When did the condition for which you are seeking treatment begin? _____

Please describe the history and onset of the present condition: _____

_____

_____

Date of Surgery (if applicable): _____ Type of Surgery: _____

What are your chief complaints due to your condition? Please check all that apply.

- ☐ `Awakened by pain
- ☐ Burning
- ☐ Difficulty falling asleep
- ☐ Difficulty finding a comfortable sleeping position
- ☐ Difficulty walking
- ☐ Diminished motion
- ☐ Dizziness
- ☐ Fatigue
- ☐ `Headaches
- ☐ Irritability
- ☐ Loss of function
- ☐ Loss of motion - stiffness
- ☐ Nausea
- ☐ Numbness
- ☐ Pain
- ☐ Constant Pain
- ☐ `Pain worse in the AM
- ☐ Pain worse in the PM
- ☐ Pain worse with activity
- ☐ Spasm
- ☐ Swelling
- ☐ Tingling
- ☐ Weakness
- ☐ Other _____

If you have pain, please rate your pain today on a scale of 0 to 10? (0 is no pain, and 10 is worst possible pain or symptoms): /10

Where is your pain located and how would you describe it? _____

_____

Rate your symptom intensity in the past 5 days:

Symptoms at their worst: /10

Symptoms at their best: /10

Please list any contraindications to treatment or precautions that we should know: _____

_____

Occupation: _____

Work Status:

☐ Employed Full Time ☐ Employed Part Time ☐ Not employed
☐ Full time student ☐ Part time student ☐ Permanently Disabled
☐ Retired

Current Ability to work:

☐ Full Duty ☐ No formal restrictions ☐ Off work
☐ Restricted duties/schedule

Please outline restrictions: _____

_____

Normal work duties:

- ☐ Sitting for extended periods
- ☐ Standing for extended periods
- ☐ Typing/computer operation
- ☐ Repetitive Bending
- ☐ Repetitive Lifting
- ☐ Lifting moderate weights
- ☐ Lifting Heavy Weights
- ☐ Walking
- ☐ Operating Heavy Equipment
- ☐ Driving

Which of these duties are you not currently able to perform and why? _____

_____

Patient Name: _____ DOB: _____ Date: _____

Please list any surgeries and procedures		
Type of Surgery	When	Results/Details

Please list any diagnostic tests and results related to your current condition		
Test	When	Results/Details

Please list other specialists seen for your current condition other than prescribing physician			
Name	Specialty	Reason	Date of Last Visit

Please enter your current height: _____ Please enter your current weight: _____

Please mark beside all conditions that you have a history of:

- ☐ Allergies
- ☐ Anxiety
- ☐ Asthma
- ☐ Bowel Dysfunction
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Headaches
- ☐ Heart Condition
- ☐ History of Smoking
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ Malaise/Fatigue
- ☐ Mental/Cognitive Disorder
- ☐ Metal Implants
- ☐ Nausea/Vomiting
- ☐ Neurological Disorder
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pregnancy (current)
- ☐ Rheumatoid Arthritis
- ☐ Shortness of Breath
- ☐ Stroke/CVA
- ☐ Syncope/Fainting
- ☐ Recent Weight Change
- ☐ Other _____

Please list all medications and supplements that you are presently taking			
Name of Medication/Supplement	Route of Administration (Oral, topical, etc)	Dosage	Frequency of Use

Have you fallen in the past 12 months? ☐ Yes ☐ No If so, how many times? _____

If you have fallen, did any fall result in an injury? ☐ Yes ☐ No ☐ N/A

Have you recently been hospitalized? ☐ Yes ☐ No If so, when were you discharged? _____

Have you received therapy in the past 12 months? ☐ Yes ☐ No If yes, how many visits? _____

In what type of home do you live? ☐ Single Level Home ☐ 2 Level Home ☐ Ground Floor Apartment ☐ Upper Level Apartment ☐ Other: _____

With whom do you live? ☐ Spouse ☐ Parent(s) ☐ Children ☐ Alone ☐ Other: _____

Are there stairs at home? ☐ Yes ☐ No If so, how many? _____

Is there a handrail? ☐ Yes ☐ No If yes, ☐ Right Side only ☐ Left Side only ☐ Both Sides

Where is the bathroom located? ☐ Lower Level ☐ Upper Level

Where is the bedroom located? ☐ Lower Level ☐ Upper Level

Do you currently smoke? ☐ Yes ☐ No If so, how many packs per day?

Did you smoke in the past? ☐ Yes ☐ No If so, how many packs _____ years _____

Do you use any other form of tobacco? ☐ Yes ☐ No

What are your goals and what do you expect to achieve with treatment? _____