Ashland Physical Therapy and Sports Medicine

Medical Questionnaire

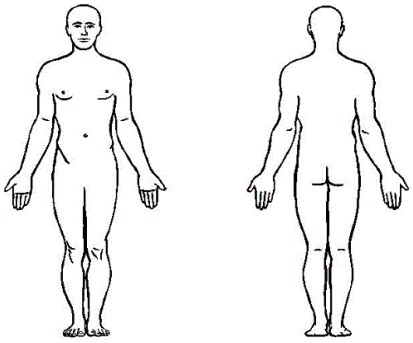
Patient Name:_____ Date of Injury: _____

What problem or diagnosis brings you here today?_____

Who referred you to PT?_____

Briefly describe your symptoms:_____

Describe how your condition or injury occurred:_____



Shade your areas of pain or discomfort on the figures to the left:

Please rate your pain on the scale below from 0 to 10:

(0 = no pain; 10 = worst pain imaginable/emergency room pain)

Pain at rest: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Pain with activity: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

What is the frequency of your pain? ○ Constant ○ Intermittent

Does the pain wake you at night? ○ Y ○ N How many times?_____

What eases your symptoms? _____ What aggravates your symptoms?_____

Are your symptoms getting ○ Better ○ Worse ○ Same Is your pain worse in the ○ AM ○ PM ○ Mid-Day ?

What activities at home, work or recreational are you unable to perform?_____

Check tests you've had for this condition: ☐ X-rays ☐ MRI ☐ Bone Scan ☐ CT Scan ☐ Nerve Tests ☐ Blood Tests ☐ Other_____

Check treatments you've had for this condition: ☐ PT ☐ Injections ☐ Chiropractic ☐ Massage ☐ Acupuncture

Current Level of Physical Activity ○ High ○ Medium ○ Low List:_____

Medical History (Check any that apply)

☐ Angina/Chest Pain	☐ Chest/Abdominal Surgery	☐ Fibromyalgia	☐ High Cholesterol	☐ Polio
☐ Asthma	☐ Coronary Artery Disease	☐ Fractures	☐ Hypoglycemia	☐ Stroke
☐ Arthritis	☐ Cancer	☐ Frequent Falls	☐ Migraine Headaches	☐ MVA
☐ Blackouts	☐ Depression	☐ Hearing Problems	☐ Major Spinal Injury	☐ Other:
☐ Blind/Vision Impairment	☐ Diabetes	☐ Heart Disease	☐ Osteoporosis	
☐ Blood Clot	☐ Diverticulitis	☐ Hepatitis	☐ Pacemaker/Nitroglycerin	
☐ Bowel or Bladder Problem	☐ Ear Infections	☐ High Blood Pressure	☐ Poor Circulation/Raynaud's	

List *ALL* Medications
(prescription or over the counter)

_____
_____
_____
_____
_____
_____

Surgeries and Prior Injuries

Year	Problem
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List any allergies:_____

What activities do you believe successful treatment will allow you to do? (e.g. carry groceries, walking in the mall, playing soccer)

_____