Medical History Questionnaire

Dba Elite Sports Medicine and Physical Therapy, LLC

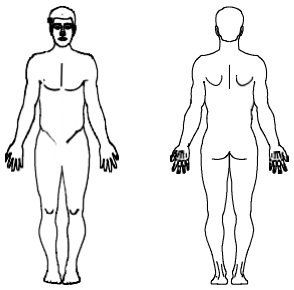
Patient Name_____ **Subscriber ID #**_____ **Primary Language**_____

What is your occupation?_____

Describe Your Current Problem and How It Began_____

Onset date/Surgery date_____

Indicate below where you have pain or other symptoms



Is this? ☐ Work Related ☐ Auto Related ☐ N/A

How often are your symptoms present?

☐ Constantly (76-100% of the day) ☐ Occasionally (26-50% of the day)
☐ Frequently (51-75% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your symptoms:

☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

How is your condition changing?

☐ Getting Better ☐ Not Changing ☐ Getting Worse

Current complaint (how you feel today):

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

Who have you seen for your current condition before today? No One

☐ Medical Doctor ☐ Massage Therapist ☐ Chiropractor ☐ Other_____
☐ Physical Therapist ☐ Acupuncturist ☐ Occupational Therapist ☐ Speech Therapist ☐ Athletic Trainer

What treatment did you receive and when?_____

Have you had x-rays, MRI, CT Scan for your area(s) of complaint? ☐ Yes ☐ No

Date(s) taken_____ **What areas were taken?**_____

In general would you say your overall health right now is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Check if you have any difficulty with: ☐ Seeing ☐ Hearing ☐ Swallowing ☐ Speaking/Talking ☐ Memory

FAMILY HISTORY

Please check if anyone in your immediate family (parents, brothers, sisters) have ever been treated for any of the following:

☐ Diabetes
☐ Heart Disease
☐ Kidney Disease
☐ Chemical Dependency (i.e. Alcoholism)
☐ Ehlers-Danlos Syndrome
☐ Other
☐ Cancer
☐ Inflammatory Arthritis (Rheumatoid, Ankylosing)
☐ Stroke
☐ Depression
☐ Osteoporosis

Medical History Questionnaire

Please check all of the following that apply to you:

□ Pain
□ Numbness/Tingling
□ Osteoarthritis
□ Rheumatoid Arthritis
□ Other Arthritic Conditions
□ Dizziness/Fainting
□ Recent Fever
□ Diabetes
□ Osteoporosis
□ Cancer If Yes, describe what kind & treatment _____

□ High Blood Pressure
□ High Cholesterol
□ Circulation Problems
□ Stroke/CVA (Date)_____
□ Blood Clots
□ Asthma
□ Emphysema/Bronchitis
□ Tuberculosis

□ Multiple Sclerosis
□ Ehlers-Danlos Syndrome
□ Epilepsy
□ MRSA
□ Depression
□ Alcohol/Drug Dependence
□ Hepatitis
□ Stomach Ulcers

□ Heart Problems If Yes, describe what kind & treatment _____

□ Kidney Problems If Yes, describe what kind & treatment _____

OTHER CONDITIONS

Please check any of the below that you have experienced in the **last 12 months?**

☐ Easy Bruising
☐ Nausea/Vomiting
☐ Fatigue
☐ Weakness
☐ Fever/Chills/Sweats
☐ Stress at Home or Work
☐ Tremors
☐ Seizures
☐ Double Vision
☐ Loss of Vision
☐ Eye Redness
☐ Joint/Muscle Swelling
☐ Excessive Bleeding
☐ Difficulty Breathing
☐ Regular Cough
☐ Arm/Leg Swelling
☐ Heart Racing in your Chest
☐ Difficulty Swallowing
☐ Heartburn/Indigestion
☐ Constipation/Diarrhea
☐ Blood in Stool
☐ Blood in Urine
☐ Skin Rash
☐ Problems Sleeping
☐ Sexual Difficulties
☐ Urinary Incontinence
☐ Problems Urinating
☐ Fecal Incontinence

How much caffeinated coffee or other caffeinated beverages do you drink per day? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer or one glass of wine, how much do you drink at an average sitting? _____

Are you now, or have you ever been, a smoker? ☐ Yes ☐ No

If Yes, how many packs of cigarettes do you smoke a day? _____

Have you ever taken an anticoagulant? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

Have you ever taken steroid medications for any reason? ☐ Yes ☐ No

During the past month, have you been feeling down, depressed, or hopeless? ☐ Yes ☐ No

During the past month, have you been bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ☐ Yes ☐ No

Are you currently pregnant or think you might be pregnant? Estimated Delivery Date? _____ ☐ Yes ☐No

Medical History Questionnaire

Please list all surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for surgery or hospitalization	
Date	**Reason for Surgery/Hospitalization**
1.	
2.	
3.	
4.	
5.	
6.	

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1.	
2.	
3.	
4.	
5.	
6.	

Medical History Questionnaire

CURRENT MEDICATIONS

Please list **ALL** medications (INCLUDING prescription, over-the-counter, herbals, vitamin/mineral/dietary (nutritional) supplements, injections, and/or skin patches) that you are **currently** taking. For each medication, please list the name, dosage, frequency, and route (by mouth, inhaler, intravenously, topically, etc.). You may attach a copy of your own list of medications if available. Only fill out the post-surgery medications if this section applies to you.

Current Medications:

Medication:_______________________________
Dosage:_______________Frequency:_________
Route: ________________

Medication:_______________________________
Dosage:_______________Frequency:_________
Route: ________________

Medication:_______________________________
Dosage:_______________Frequency:_________
Route: ________________

Medication:_______________________________
Dosage:_______________Frequency:_________
Route: ________________

Medication:_______________________________
Dosage:_______________Frequency:_________
Route: ________________

Medication:_______________________________
Dosage:_______________Frequency:_________
Route: ________________

Medication:_______________________________
Dosage:_______________Frequency:_________
Route: ________________

Post-Surgery Medications:

Medication:__________________________________
Dosage:_______________Frequency:____________
Route: ________________

Medication:__________________________________
Dosage:_______________Frequency:____________
Route: ________________

Medication:__________________________________
Dosage:_______________Frequency:____________
Route: ________________

Medication:__________________________________
Dosage:_______________Frequency:____________
Route: ________________

Medication:__________________________________
Dosage:_______________Frequency:____________
Route: ________________

Medication:__________________________________
Dosage:_______________Frequency:____________
Route: ________________

Medication:__________________________________
Dosage:_______________Frequency:____________
Route: ________________

****During the course of your Physical Therapy, if there are *<u>any changes</u>* (type or dosage) in your medications or supplements, it is important that you notify your therapist!****

I certify to the best of my knowledge, that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider/ practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this provider/ practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that this provider/practitioner may need to contact my physician if my condition needs to be co- managed. Therefore, I give authorization to this provider/practitioner to contact my physician, if necessary.

Patient/Responsible Party Signature: ________________________________ **Date:** _________________

Reviewed with Patient:____ **Date:** _________________

Evaluating Physical Therapist's Signature