FREEDOM
PHYSICAL THERAPY SERVICES, S.C.

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **Date of evaluation:** _____

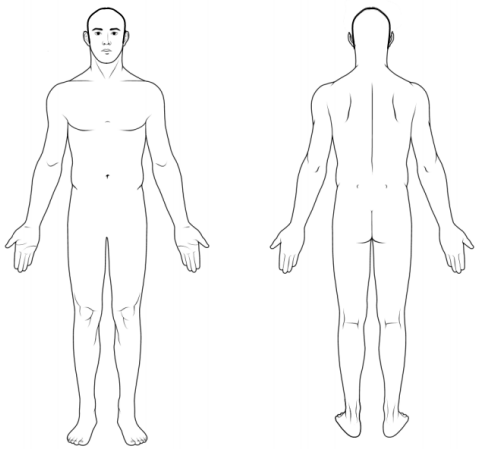
Physicians/providers involved in your care: _____

1) What are your current symptoms?

2) When and how did they begin?

3) Have you had previous treatment for this condition? If so, what type and when?

4) Please shade in the area of your current symptoms:



Symptom Key:
P = pain
N = numbness
T = tingling
W = weakness
O = other:
_____
_____

5) Do you now or have you ever had the following medical problems (check if yes)?

____Asthma ____Allergies ____Cancer ____Diabetes ____DVT/Blood Clots
____Liver Disease/Hepatitis ____High Blood Pressure ____Heart Problems/Chest Pain/Angina
____Kidney Problems ____Rheumatoid Arthritis ____Skin Conditions ____Stroke
____Osteoporosis / Osteopenia ____ Infections including TB/HIV
____Surgery, type: _____

6) Are you currently pregnant? ____Yes ____No

7) Do you now or have you ever experienced the following (check if yes)?

____Migraines/Headaches ____Jaw Pain/Clicking/Locking/Grinding/Clenching
____Loss of Balance/Falls/Vertigo/Dizziness ____Swelling/Lymphedema
____Bowel/Bladder Problems ____Pelvic/Abdominal Pain ____ Traumatic Injury

Please Turn Over and Complete Back Side

8) Please list or provide a copy of medications/supplements you are taking:

_____

_____

9) Current Job: _____ Full Time: _____ Part Time: _____

10) Have you missed work due to this condition? ____No ____Yes; How Much?_____

11) Job Requirements: _____Prolonged Sitting ____Prolonged Standing ____ Lifting: _____Lbs.

Other: _____

12) Which work, household activities, hobbies and sports are <u>most</u> limited by your current condition?

13) Which position, activities or medications make your symptoms feel better?

14) How limited overall are your normal activities due to symptoms?

0 1 2 3 4 5 6 7 8 9 10

Bed Rest Normal

15) Circle the number that best indicates your current symptoms.

0 1 2 3 4 5 6 7 8 9 10

No Pain Unable to Function

15) What are your personal goals for therapy?

_____

_____

16) Is there anything else we can help you with?

_____ _____

Patient Signature Therapist Signature

Thank you for choosing Freedom Physical Therapy Services!