

Patient information

Name: (last) _____ (first) _____ (middle initial) _____

Date of Birth: _____ Age: _____ Sex: _____

Referring Physician: _____ Primary Care Physician: _____

Describe why you are seeking Physical Therapy

Date this began (if chronic, please identify exacerbation date): _____

Have you had this issue in the past? (circle) Yes No If yes, did you receive treatment? (circle) Yes No

What type of treatment did you receive? _____ Was it effective? (circle) Yes No

History of present illness/injury

How did your condition develop? _____

Occupation history: _____ Has your work status changed? (circle) Yes No

Are you receiving workers compensation or in litigation? (circle) Yes No

Tests you have had (check all that apply or have been conducted in the last five years)

<input type="checkbox"/> Arthroscopy	<input type="checkbox"/> Doppler/Ultrasound	<input type="checkbox"/> Myelogram	<input type="checkbox"/> X-ray
<input type="checkbox"/> Bone Scan	<input type="checkbox"/> EMG/NCV	<input type="checkbox"/> Stress Test	<input type="checkbox"/> Other _____
<input type="checkbox"/> CT Scan	<input type="checkbox"/> MRI	<input type="checkbox"/> Vestibular	<input type="checkbox"/> Other _____

Systems review (please check (✓) all that apply to your current condition.....and X conditions you have ever had in the past)

<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Hearing issues	<input type="checkbox"/> Phlebitis / blood clots
<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/> Depression	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Pregnant
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Psychological tx
<input type="checkbox"/> Angina (chest pain)	<input type="checkbox"/> Drug abuse	<input type="checkbox"/> Heart surgery	<input type="checkbox"/> Skin disease
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Stress
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fainting or dizziness	<input type="checkbox"/> Joint replacement	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Kidney / Liver disease	<input type="checkbox"/> TMJ
<input type="checkbox"/> Bladder changes	<input type="checkbox"/> Fractures	<input type="checkbox"/> Lung disease	<input type="checkbox"/> Tobacco use
<input type="checkbox"/> Bowel changes	<input type="checkbox"/> Frequent falls	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Tumors
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gastrointestinal issues	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Urinary tract infection
<input type="checkbox"/> Carpal tunnel synd.	<input type="checkbox"/> Gout	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Unexplained weight loss
<input type="checkbox"/> Circulatory issues	<input type="checkbox"/> Headaches	<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/> Vision issues

When was your last physical? _____ Do you know your average blood pressure? _____

List any surgical history (include dates) _____

List current medications (separate paper is available) _____

List known allergies _____

Patient name: (last) _____ (first) _____ Date of Birth: _____

Describe your present illness/injury

<input type="checkbox"/> Sharp	<input type="checkbox"/> Numbness	<input type="checkbox"/> Tingling	<input type="checkbox"/> Dull ache
<input type="checkbox"/> Shooting	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Burning	<input type="checkbox"/> Other _____

<input type="checkbox"/> Constant (76-100%)	<input type="checkbox"/> Frequent (51-75%)	<input type="checkbox"/> Occasional (26-50%)	<input type="checkbox"/> Intermittent (24% or less)
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Circle intensity of pain at rest: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

Circle intensity of pain with movement: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

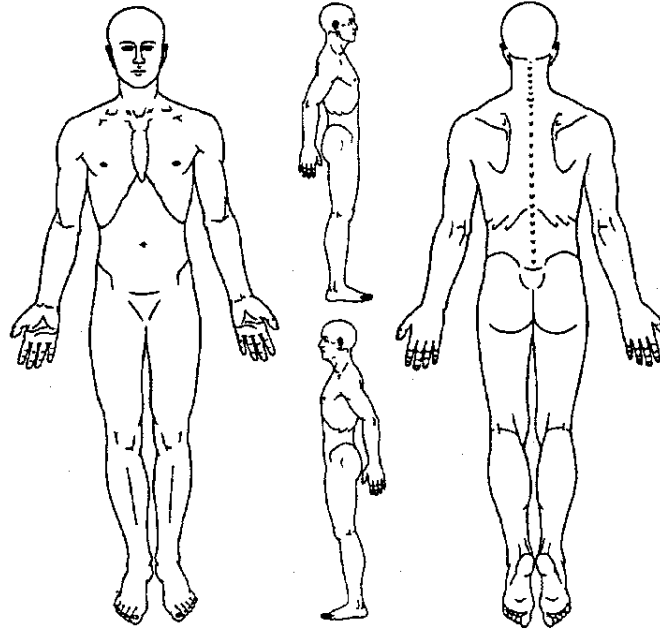
What makes it feel better _____ What makes it feel worse _____

When are your symptoms the best and worst?(please X boxes below)

Best time	<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Night
Worst time	<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Night

Please label the diagram where you have symptoms with the following symbols:

Numbness - - - -	Pins / Needles oooo	Burning ^^^^	Aching xxxx	Stabbing ⊕⊕⊕⊕
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In signing below I acknowledge having answered this questionnaire to the best of my knowledge.

Patient Signature: _____ Date: _____

Thank you for taking the time to complete this form and letting AIR provide you Physical Therapy.

I have read this medical history questionnaire and have discussed concerns or made appropriate referrals.

Therapist Signature: _____ Date: _____