NORTHWEST SPORT AND SPINE
An Affiliate of IRG Physical & Hand Therapy

# MEDICAL QUESTIONNAIRE

## GENERAL INFORMATION

Name _____ DOB ____/____/_____ Age _____

Employer: _____ Occupation: _____

Date of Injury or Onset of Symptoms: ___/___/_____ Date of Surgery (if applicable): ___/___/_____

Diagnosis, injury, or chief complaint(s): _____

Side of Injury: ❑ Right ❑ Left ❑ Bilateral

Where did your injury occur? ❑ Work ❑ Auto/MVA ❑ Home ❑ Other: _____

Briefly describe how your injury occurred: _____

Briefly describe your present symptoms: _____

Does your pain level change over the course of day and night?: _____

Have you had any of the following treatment and/or tests for this condition? *(check all that apply)*

❑ Physical Therapy ❑ Occupational Therapy ❑ Chiropractic ❑ Massage ❑ Home Health ❑ Acupuncture

❑ Hospitalization ❑ X-Rays ❑ MRI ❑ CT Scan ❑ Bone Scan ❑ Injections ❑ Other: _____

Please list the names of practitioners you have seen for this condition:_____

_____

What do you hope to accomplish with therapy? *(your personal goals):* _____

_____

## MEDICAL HISTORY *(check all that apply)*

❑ Allergies: _____
❑ Anxiety
❑ Asthma
❑ Arthritis
❑ Blood Clots
❑ Bruise Easily
❑ Cancer: _____
❑ **Other:** _____
❑ Depression
❑ Diabetes
❑ Dizziness/Vertigo
❑ Fibromyalgia
❑ Fractures
❑ Heart Disease
❑ Hepatitis
❑ High Blood Pressure
❑ High Cholesterol
❑ HIV/AIDS
❑ Hypoglycemia
❑ Kidney Problems
❑ MRSA
❑ Multiple Sclerosis
❑ Osteoporosis
❑ Seizures
❑ Sensitivity to heat or ice
❑ Stroke
❑ Traumatic Injury
❑ **No Significant Medical History**

## OTHER MEDICAL INFORMATION

Height: _____ Weight:_____ Do you have a pacemaker? ❑ Yes ❑ No Are you pregnant? ❑ Yes ❑ No

Do you smoke tobacco? ❑ Yes ❑ No If yes, how much_____ how long _____

Do you drink alcohol? ❑ Yes ❑ No If yes, how much_____

How would you rate your overall health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you exercise outside of normal daily activities? ❑ Yes ❑ No

List any surgeries/major accidents/illnesses with dates: _____

_____

List all current medications *(or provide front desk with a list that can be copied into your medical record)*: _____

_____

Signature _____ Date _____

*(Parent or Guardian signature if patient is a minor)*