PATIENT MEDICAL HISTORY QUESTIONNAIRE

Please assist us in conducting a thorough and accurate examination by completing this very important background information. Do not hesitate to ask your therapist for assistance if there is a question that may require clarification, or if there is a question that you do not understand.

Patient Name: _____ **Birth Date:** _____ **Age:** _____
Gender: ❑M ❑F I am: ❑R-handed ❑L-handed
Marital Status: ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed
Occupation: _____ Pre-Injury Hours/week:_____
Current hours/week: _____ Has your doctor given you any activity limitations? YES/NO
If yes, describe: _____
Leisure activities/recreation/sports:
_____
How often? (pre-injury and current) _____

Please mark (X) any of the following whose care you are under:
___ Medical Doctor (MD) ___ Osteopath ___ Dentist
___ Psychiatrist/Psychologist ___ Physical Therapist ___ Chiropractor
Approximate date of **last physical examination by MD**, if any: _____
Please describe for what reason you saw any of the other above professionals, **within the last 3 months**:
_____
Please list any **specialists** involved in your care (cardiac, orthopedic, allergist, etc.):
_____
List any **other professionals** involved in your health (acupuncture, nutritionist, herbalist, trainer, etc.):
_____

ALLERGIES:
*Please mark (X) if you have ever experienced **any reaction** to the following:*
___ *Aspirin* ___ *Penicillin* ___*Latex* ___*Steroids*
*Please list any **medication(s) you are allergic** to:* _____
*List any **other allergies** we should know about:* _____

MEDICATIONS: Which of the following medications have you taken in the last week?

(circle if yes)	**Physician Prescribed?**
Aspirin	YES/NO
Tylenol	YES/NO
Anti-inflammatories (Advil/Motrin/Ibuprofen etc.)	YES/NO
Stomach ulcer medications	YES/NO
Vitamins/mineral supplements	YES/NO
Herbals/Remedies	YES/NO

Others NOT prescribed by a physician_____
Please list any other physician-prescribed medication you are currently taking (INCLUDING pills, injections, and/or skin patches): (OR, *attach* a list)
1. _____ 2._____ 3._____
4. _____ 5. _____ 6._____

How many times have you **fallen** within the last **year**? _____ How many of these have resulted in injury? _____

Please list **ALL SURGERIES** and **SIGNIFICANT INJURIES** (including sprains, dislocations, fractures) and dates:

Date	Injury/Surgery	Date	Injury/Surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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/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
Have you ever been threatened, hurt, or made to feel afraid or humiliated by your partner or someone close to you? YES/NO

OVER →

How much **caffeinated** coffee or **caffeine-containing** beverages do you drink per day? _____
Recreational marijuana use: Do you smoke marijuana, or otherwise ingest it? YES/NO
If yes, how often and how much? _____
Nicotine use: Do you smoke or chew tobacco, or otherwise use "electronic cigarettes?" YES/NO
If yes, how much and how often? _____ for how many years? _____
If you PREVIOUSLY smoked but **quit,** how many packs per day? _____ for how many years? _____
Alcohol use: How many days per week do you drink **alcohol**? (please circle): 0-1 1-2 2-3 3-4 4-5 5-6 6-7
If 1 drink equals one 12 oz beer, or one 6 oz glass of wine, or 1.5 oz of liquor, how much do you drink at an average sitting? (# of drinks) _____
How many times in the **past year** have you had:
for MEN, 5 or more drinks in a day _____ ; for WOMEN, 4 or more drinks in a day _____

Do you have any **immediate family** (parents, brothers, sisters) **history** of:

YES NO Diabetes	YES NO Cancer	YES NO Heart disease
YES NO High blood pressure	YES NO Depression	YES NO Stroke
YES NO Kidney disease	YES NO Gout	YES NO Hemophilia
YES NO Osteoporosis	YES NO Osteoarthritis	YES NO Sickle Cell Anemia
YES NO Alcoholism (chemical dependency)	YES NO Inflammatory Arthritis (Rheumatoid, Ankylosing)	

Have **YOU** EVER been diagnosed as having any of the following conditions?

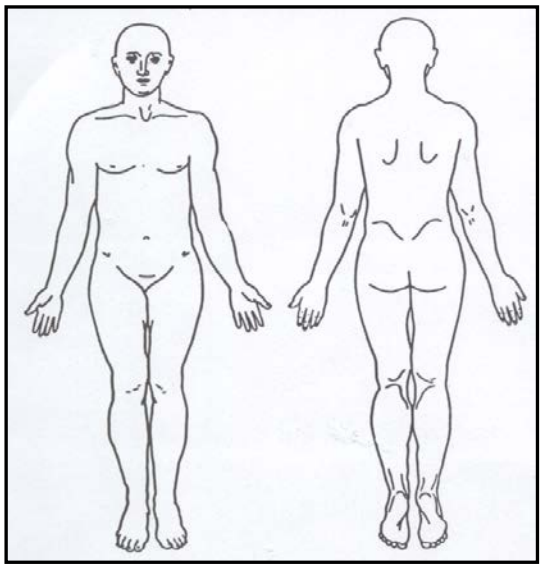
YES NO High blood pressure	YES NO Circulation problems	YES NO Asthma
YES NO Stomach ulcers	YES NO Thyroid problems	YES NO Diabetes
YES NO Multiple sclerosis	YES NO Rheumatoid arthritis	YES NO Other arthritic conditions
YES NO Depression	YES NO Hepatitis	YES NO Tuberculosis
YES NO Stroke	YES NO Blood clots	YES NO Osteoporosis

YES NO Cancer If YES what kind: _____ YES NO Heart Problems If YES what kind_____
YES NO Chemical dependency (i.e., alcoholism) YES NO Kidney disease If YES what kind_____
YES NO Other_____

Please circle any **recent developments** of the following that are **NEW, UNUSUAL, or ATYPICAL** for you:

YES NO weight loss/gain	YES NO joint/muscle swelling	YES NO nausea/vomiting
YES NO easy bruising	YES NO dizziness/lightheadedness	YES NO excessive bleeding
YES NO fatigue	YES NO difficulty breathing	YES NO weakness
YES NO regular cough	YES NO fever/chills/sweats	YES NO arm/leg swelling
YES NO numbness or tingling	YES NO heart racing in your chest	YES NO tremors
YES NO difficulty swallowing	YES NO seizures	YES NO heartburn/indigestion
YES NO double vision	YES NO constipation/diarrhea	YES NO loss of vision
YES NO blood in stools	YES NO eye redness	YES NO post menopause
YES NO skin rash	YES NO problems sleeping	YES NO urinary incontinence
YES NO sexual difficulties	YES NO blood in the urine	YES NO night sweats
YES NO hearing problems	YES NO stress at home or work	

YES NO problems urinating (difficulty starting, painful etc.) YES NO pregnant or think you might be pregnant



Please mark the body diagram by indicating
the location of any of the following sensations:
Pain +++++ Numbness ------ Tingling xxxxx

Please list any further concerns that you would like us to address :

_____

_____
Patient Signature Date

_____
Therapist Signature Date