Outpatient Therapy Medical History Questionnaire

Rev 2/19

PATIENT NAME: ______________________________

BIRTHDATE: ______________________________

DATE: ______________________________

Please Answer The Following Questions:

1) Injury/Onset Date: ____________________

2) Preferred Language: ____________________________

3) Surgery Performed: No □ Yes □ Date of Surgery: ________________ Type of Surgery: ______________________

4) Prior Hospitalization: No □ Yes □ Dates of Hospitalization: ____

5) How did you injure yourself? ____

6) What is your primary complaint/concern? ____

7) Do you experience pain? No □ Yes □
   If yes, please circle the number that represents your average daily pain:
   (no pain) 0----1----2----3----4----5----6----7----8----9----10 (worst pain)
   What makes your pain worse? ____

   What makes your pain better? ____

8) Have you recently experienced loss of appetite, anxiety/mood changes, or significant weight gain/loss?
   No □ Yes □ If yes, please explain: ____

9) Are you experiencing any social or emotional difficulties at home/work that we should be aware of?
   No □ Yes □ If yes, please explain: ____

10) Are you experiencing any abuse at home?
    No □ Yes □ If yes, please explain: ____

11) Please check off any of the following medical issues that may apply to you:

□ Alzheimer's	□ Fibromyalgia	□ Muscular Dystrophy
□ Cardiovascular Disease	□ Fracture or Suspected Fracture	□ Obesity
□ Cauda Equina Syndrome	□ High Blood Pressure	□ Osteoarthritis
□ Cerebral Vascular Accident (Stroke)	□ History of Cancer	□ Parkinson's
□ Current Infection	□ Huntington's	□ Rheumatoid Arthritis
□ Diabetes Type 1	□ Immunosuppression	□ Traumatic Brain Injury
□ Diabetes Type 2	□ Lupus	

□ Other: □ Pregnant □ Joint Replacement/Implant □ Seizures □ Pacemaker

12) Do you have any allergies? (i.e. medication, latex) No □ Yes □ ____

13) Please list current medications, herbals or vitamins or provide med list:

Medication	Dose/Frequency	Reason for Taking

14) What do you want to achieve by coming to therapy? What are your goals? ______________________________
____

Patient or Guardian Signature: ____________________________________ Date: ____________ Time: ______

Clinician Signature/Print: ____ Date: ____________ Time: ______