



# Pinnacle Physical Therapy

## Medical History Questionnaire

The purpose of this questionnaire is to determine if you might have a medical condition that could affect your treatment here. This information is confidential. Under certain circumstances, we may need to obtain your physician's opinion to determine if you qualify for a particular course of therapy.

Patient

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_

Alternate Phone: (    ) \_\_\_\_\_ work

Alternate Phone: (    ) \_\_\_\_\_ cell

### EMERGENCY CONTACT:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: (    ) \_\_\_\_\_

Alternate Phone: (    ) \_\_\_\_\_

### PLEASE ANSWER THE FOLLOWING QUESTIONS:

Are you currently taking any prescription or non-prescription medications? YES NO

If yes, LIST:

Muscle Relaxers \_\_\_\_\_

Anti-Inflammatory \_\_\_\_\_

Pain Medications \_\_\_\_\_

Other Meds \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Your chief complaint: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

If not an injury, date of onset of symptoms: \_\_\_\_\_

Date of 1<sup>st</sup> doctor visit for this injury: \_\_\_\_\_

Date last worked due to injury: \_\_\_\_\_

Is an attorney involved in this case: YES NO

Date returned to work after this injury: \_\_\_\_\_

Have you had surgery for this injury: YES NO

Type of Surgery: \_\_\_\_\_

**Have you had any of the following Medical or Rehabilitative Services for this injury: YES NO**

Chiropractor

\_\_\_\_\_

CT Scan

\_\_\_\_\_

X-rays

\_\_\_\_\_

EMG/NCV

\_\_\_\_\_

General Practitioner

\_\_\_\_\_

MRI

\_\_\_\_\_

Massage Therapy

\_\_\_\_\_

Myelogram

\_\_\_\_\_

Neurologist

\_\_\_\_\_

Occupational Therapy

\_\_\_\_\_

Orthopedist

\_\_\_\_\_

ER Care

\_\_\_\_\_

Physical Therapy

\_\_\_\_\_

Podiatrist

\_\_\_\_\_

\_\_\_\_\_

Other

\_\_\_\_\_

**Do you have or have you ever had any of the following: YES      NO**

Asthma, Bronchitis, Emphysema

\_\_\_\_\_

Severe Frequent Headaches

\_\_\_\_\_

Shortness of Breath/Chest Pain

\_\_\_\_\_

Vision or Hearing Difficulties

\_\_\_\_\_

Coronary Heart Disease/Angina

\_\_\_\_\_

Numbness or Tingling

\_\_\_\_\_

Do you have a pacemaker?

\_\_\_\_\_

Dizziness or Fainting

\_\_\_\_\_

Heart Attack or Surgery

\_\_\_\_\_

Weakness

\_\_\_\_\_

High Blood Pressure

\_\_\_\_\_

Weight Loss/Energy Loss

\_\_\_\_\_

Stroke/TIA

\_\_\_\_\_

Hernia

\_\_\_\_\_

Blood Clot

\_\_\_\_\_

Vericose Veins

\_\_\_\_\_

Epilepsy/Seizure

\_\_\_\_\_

Allergies

\_\_\_\_\_

\_\_\_\_\_

Thyroid Trouble/Goiter

\_\_\_\_\_

Pins or Metal Implants

\_\_\_\_\_

\_\_\_\_\_

Anemia

\_\_\_\_\_

Joint Replacements

\_\_\_\_\_

\_\_\_\_\_

Infectious Disease

\_\_\_\_\_

Neck Injury/Surgery

\_\_\_\_\_

\_\_\_\_\_

Diabetes

\_\_\_\_\_

Shoulder Injury/Surgery

\_\_\_\_\_

\_\_\_\_\_

Cancer/Chemotherapy/Radiation

\_\_\_\_\_

Elbow/Hand Injury/Surgery

\_\_\_\_\_

\_\_\_\_\_

Arthritis/Swollen Joints

\_\_\_\_\_

Back Injury/Surgery

\_\_\_\_\_

\_\_\_\_\_

Osteoporosis

\_\_\_\_\_

Knee Injury/Surgery

\_\_\_\_\_

\_\_\_\_\_

Gout

\_\_\_\_\_

Leg/Ankle/Foot Injury/Surgery

\_\_\_\_\_

Emotional/Psychological Problems

\_\_\_\_\_

Are you Pregnant?

\_\_\_\_\_

Sleeping problems/difficulties

\_\_\_\_\_

Do you smoke?

\_\_\_\_\_

**List any other information that would assist us in your care:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Are you aware of what your diagnosis is? YES NO**

**Based upon your awareness, what are your expectations/goals while in this program?**

\_\_\_\_\_

\_\_\_\_\_

**Would you like to speak with a social worker about the aspects of your rehabilitation program?**

**YES NO**

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Please be sure to talk to your clinician if this information changes.**