

Medical History Questionnaire

Name: _____	Date Completed: _____
Date of Birth: _____	Onset Date: _____
Emergency Contact: _____	Relationship: _____
Phone # 1: _____	Phone # 2: _____

Do you have a history of any of the following?

High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina/Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No

In the past 3 months have you experienced any of the following?

Change in your health	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nausea/Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Unexplained weight change	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Change in appetite	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fever/Chills/Sweats	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Change in bowel/bladder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Numbness/Tingling	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Upper respiratory infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answered "Yes", please describe: _____

Are you currently pregnant Yes No

Do you smoke tobacco? Yes No

Do you drink alcohol regularly? Yes No

Have you had 2 or more falls in the past year or any fall with injury in the past year? Yes No

Please answer the following questions regarding your current condition:

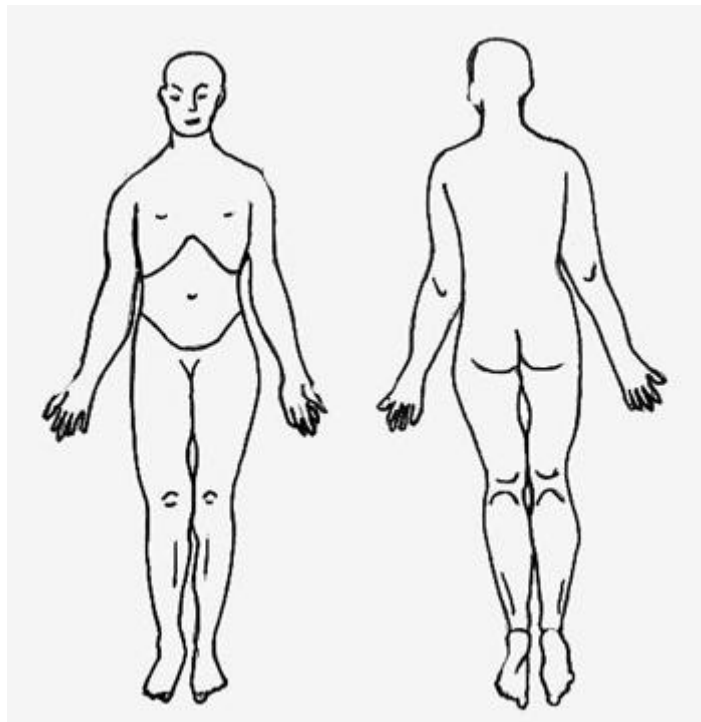
Have you had any previous treatment for your current condition?				
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Injections	<input type="checkbox"/> Other: _____	
Results: _____				
Have you had any of the following diagnostic tests for your current condition?				
<input type="checkbox"/> MRI	<input type="checkbox"/> X-ray	<input type="checkbox"/> CT Scan	<input type="checkbox"/> Bone Scan	<input type="checkbox"/> EMG <input type="checkbox"/> Other: _____
Results: _____				
My symptoms are: <input type="checkbox"/> Getting Worse <input type="checkbox"/> Staying the Same <input type="checkbox"/> Getting Better				

I currently have difficulty with the following daily activities as a result of my current condition:

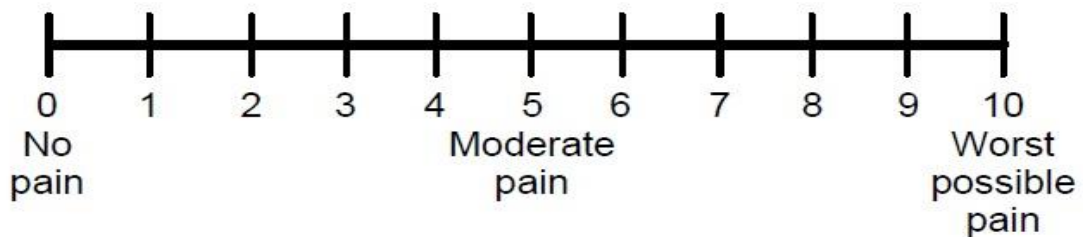
<input type="checkbox"/> Standing/Walking	<input type="checkbox"/> Sitting	<input type="checkbox"/> Driving	<input type="checkbox"/> Getting Up From Chair
<input type="checkbox"/> Bending/Lifting	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Dressing/Grooming	<input type="checkbox"/> Work Activities
<input type="checkbox"/> Reaching Overhead	<input type="checkbox"/> Reaching Behind Back	<input type="checkbox"/> Grasping	
<input type="checkbox"/> Other: _____			

USE THE FOLLOWING DRAWING AND SYMBOLS SHOWN TO INDICATE THE LOCATION AND TYPE OF SYMPTOMS YOU ARE EXPERIENCING AT THE PRESENT TIME:

SHARP PAIN /////	ACHINESS XXXXX	BURNING !!!!	PINS & NEEDLES 00000	NUMBNESS +++++
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USE A CIRCLE TO RATE YOUR PAIN AT PRESENT ON THE 0-10 PAIN RATING SCALE BELOW:



RATE YOUR PAIN ON A SCALE OF 0-10 AT BEST AND AT WORST IN THE SPACES PROVIDED:

AT BEST: _____

AT WORST: _____

PLEASE LIST ALL MEDICATIONS, VITAMINS AND SUPPLEMENTS YOU ARE CURRENTLY TAKING. PLEASE CIRCLE THE METHOD, LIST THE DOSAGE AND CIRCLE THE FREQUENCY BY WHICH YOU TAKE THEM.

Medications, Vitamins, Supplements	Method (Circle One)	Dosage	Frequency (Circle One)
	Oral Patch Inhaler Injection Other:		1x/day 2x/day 3x/day Other:
	Oral Patch Inhaler Injection Other:		1x/day 2x/day 3x/day Other:
	Oral Patch Inhaler Injection Other:		1x/day 2x/day 3x/day Other:
	Oral Patch Inhaler Injection Other:		1x/day 2x/day 3x/day Other:
	Oral Patch Inhaler Injection Other:		1x/day 2x/day 3x/day Other:
	Oral Patch Inhaler Injection Other:		1x/day 2x/day 3x/day Other:
	Oral Patch Inhaler Injection Other:		1x/day 2x/day 3x/day Other:
	Oral Patch Inhaler Injection Other:		1x/day 2x/day 3x/day Other:

BODY MASS INDEX (BMI) – TO BE COMPLETED BY THERAPIST OR OTHER EXCEL SUPPORT STAFF (Medicare Patients Only):

Weight: _____	Height: _____	Calculated BMI (For Internal Use Only): _____
<u>Normal Parameters:</u> Age 65 years and older - BMI ≥ 23 and < 30 Age 18-64 years - BMI ≥ 18.5 and < 25		

I hereby consent to evaluation and/or treatment of my condition by a licensed physical therapist employed by or under contract with E & A Therapy, Inc. I am aware that the physical therapist will inform me of the expected benefits and possible discomfort, which may result from skilled physical therapy care.

I am aware that there is not a guarantee that the proposed course of treatment will improve my condition and that it is possible, although unlikely, that the course of treatment may cause additional pain or discomfort or aggravate my condition. I confirm that I have read and fully understand this consent form.

In regards to communication with my therapist, I am aware that e-mail and text messaging is not a secure method of communicating. By initiating or responding to an e-mail or text message, I am giving my consent to communicate in this manner and understand that there are risks to my protected health information. **Patient's Initials** _____

PATIENT SIGNATURE: _____ DATE: _____

FORM HAS BEEN READ AND REVIEWED BY THERAPIST: YES NO PT INITIALS: _____