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Clear Form

Medical History Questionnaire

Name: _____ Date Completed: _____

Date of Birth: _____ Onset Date: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone #: _____

Do you have a history of any of the following?

High Blood Pressure	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Hepatitis/HIV	☐ Yes	☐ No
Angina/Chest Pain	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Depression	☐ Yes	☐ No

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

Change in your health	☐ Yes	☐ No	Nausea/Vomiting	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No	Unexplained weight change	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No	Change in appetite	☐ Yes	☐ No
Fever/Chills/Sweats	☐ Yes	☐ No	Change in bowel/bladder	☐ Yes	☐ No
Numbness/Tingling	☐ Yes	☐ No	Upper respiratory infection	☐ Yes	☐ No

If you answered "Yes", please describe: _____

_____

Are you currently pregnant ☐ Yes ☐ No Do you drink alcohol regularly? ☐ Yes ☐ No

Do you smoke tobacco? ☐ 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?

☐ Chiropractic ☐ Physical Therapy ☐ Injections ☐ Other: _____

Results: _____

Have you had any of the following diagnostic tests for your current condition?

☐ MRI ☐ X-ray ☐ CT Scan ☐ Bone Scan ☐ EMG ☐ Other: _____

Results: _____

My symptoms are: ☐ Getting Worse ☐ Staying the Same ☐ Getting Better

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

☐ Standing/Walking	☐ Sitting	☐ Driving	☐ Getting Up From Chair
☐ Bending/Lifting	☐ Sleeping	☐ Dressing/Grooming	☐ Work Activities
☐ Reaching Overhead	☐ Reaching Behind Back	☐ Grasping	

☐ Other: _____

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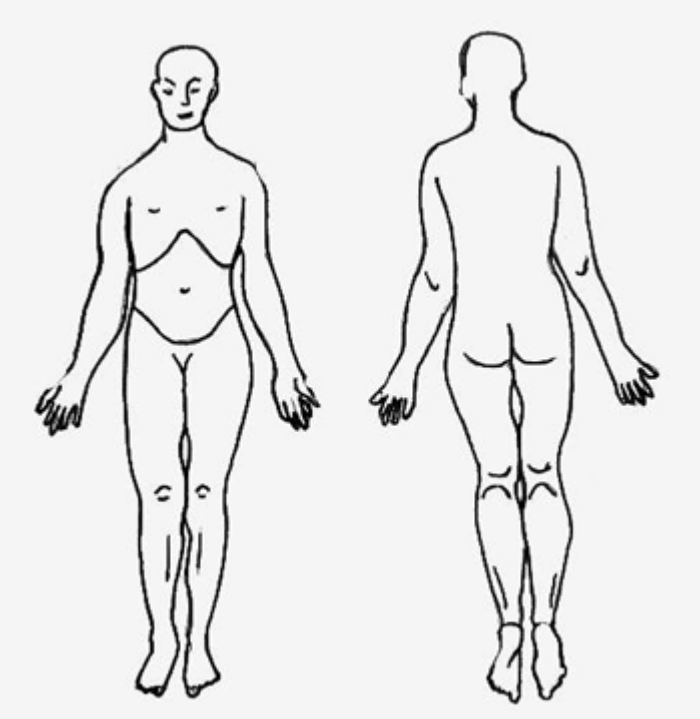
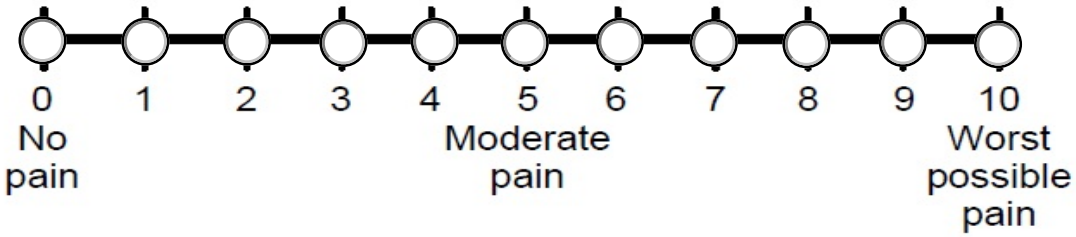
Patient's Name: _____
Date of Birth: _____

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	BURNING	PINS & NEEDLES	NUMBNESS
/////	XXXXX	!!!!!	00000	+++++



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: _____

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Patient's Name: _____
Date of Birth: _____

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)
	_____ Other:		_____ Other:
	_____ Other:		_____ Other:
	_____ Other:		_____ Other:
	_____ Other:		_____ Other:
	_____ Other:		_____ Other:
	_____ Other:		_____ Other:
	_____ Other:		_____ Other:
	_____ Other:		_____ Other:

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 (OR PARENT/LEGAL GUARDIAN) SIGNATURE: _____ DATE: _____

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