ProFormance Rehabilitation
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ProFormance Rehab

Medical History Questionnaire

Name: _____
Referring Provider: _____
Diagnosis: _____
Birthdate: _____ Age: _____

What problem or complaint can we help you with today? _____
_____

Is this related to an injury or accident? Yes No Date of accident: _____
If yes, check which applies: Work Motor Vehicle Other (specify) _____
_____

Are you currently off work because of this problem? Yes No Light Duty
If yes, last day worked: _____ Occupation: _____
How and when did your symptoms start? _____ Date: _____
Have you had this problem before? _____
What tests or treatment have you had for this problem? _____
Have you had any diagnostics? X-rays MRI Bone Scan CAT scan Nerve tests Blood tests
Other Results: _____
Have you had surgery relating to this condition? Yes No Explain: _____ Date: _____
List all medications you are currently taking for this or other problems: _____
_____

Currently, would you say your health is: Excellent Good Poor

Have you had any of the following:

Weakness	Numbness or tingling	Dizziness or nausea
Headaches	Change in bowel/bladder	Pain with cough/sneeze
Blurred vision	Balance problems or falls	Dropping things
Night pain	Unexplained weight loss	Fainting/drop attacks

What is your pain intensity? (please circle below)
No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

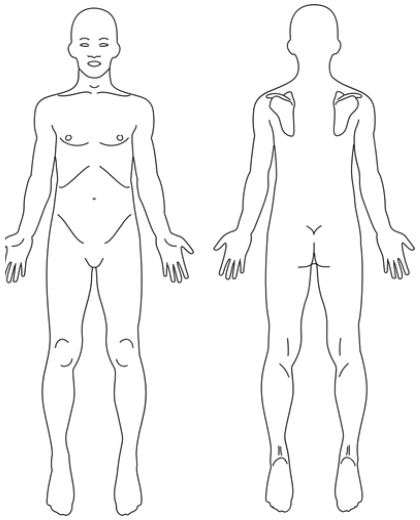
Which of these words best describes your pain?

Sharp	Dull	Aching	Burning	Radiating	Numb/tingling
Radiating	Constant	Intermittent	Buckling	Locking	Giving way

Other _____

Do you have days or periods when you are completely pain free? Yes No

Please indicate your painful areas:



How is your current condition progressing overall?

Improving Staying the same Getting worse

What makes your problem(s) BETTER? Heat Ice Rest Medication Change in position Exercise Other _____

What makes your problem(s) WORSE? Sitting Standing Walking Twisting Bending Squatting Stairs Rising from chair Pushing/pulling Kneeling Reaching Lifting Reclining Other _____

Are you able to continue your usual recreational activities? Yes No Limited (please explain)

_____

Please list your usual exercise habits/sports/recreational activities: _____

_____

How many days per week do you exercise? _____ Average # minutes per day? _____

Have you had any falls in the past year? Yes No

Are you currently pregnant? Yes No Not Applicable

Have you had any of the following at any time in your life? Please circle

Asthma	Allergies	Lung problems	Heart disorder	High Blood Pressure
Lupus	Stroke	Fibromyalgia	Diabetes	Bleeding disorder
Polio	Tuberculosis	Osteoporosis	Blood Clots/DVT	Concussion
Cancer	Arthritis	Seizures	Broken bone	Major Accident/Trauma
Whiplash	Sprain/Strain	Nerve disorder	Metal Implant	Headaches
Anxiety	Depression	Connective tissue disorder	Allergy to latex/adhesives	

Orthopedic Surgery: _____ Other Surgery: _____

Please explain any circled items: _____

_____

Any other conditions we should be aware of? _____

What are your goals that you are hoping to achieve with physical therapy? _____

_____