Progressive
Physical Therapy & Wellness

BP	/
Height	
Weight	
BMI	
OFFICE USE ONLY	

MEDICAL HISTORY QUESTIONNAIRE

The purpose of this form is to help us understand your health status. Please complete the questionnaire to the best of your ability. If you are unsure how to answer, the therapist will assist you during your exam. This form will be a part of your medical record.

Name: ____ Age:________ Date of Birth:___________________________

Referring Physician:____________________________________ Primary Care Physician:_______________________________

Please best describe why you have been referred to Physical Therapy. Why are you here to see us today?

____

Have you had any other tests or previous treatments for this episode in the past year? Please list any recent x-rays, MRIs, CT scans,etc.____

____

Do you now, or have you ever had any of the following:

- ☐ Cancer
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Stroke
- ☐ Severe Headache
- ☐ Numbness/Tingling
- ☐ Dizziness/Fainting
- ☐ Unexplained Weight Loss
- ☐ Seizures
- ☐ Thyroid Problems
- ☐ Osteoporosis
- ☐ Sleep Disturbance
- ☐ Arthritis
- ☐ Diabetes

Please list any surgeries or falls pertinent to this episode/ injury. Include dates: ____

____

If you are experiencing pain, please describe by circling all that apply:

Constant Intermittent Sharp Dull Aching Stabbing Numbness Pins/ Needles

Rate your current pain on a scale of 0 – 10 (0 = No pain at all, 10 = Need to go to the emergency room):

At Best	0	1	2	3	4	5	6	7	8	9	10
At Worst	0	1	2	3	4	5	6	7	8	9	10
Currently	0	1	2	3	4	5	6	7	8	9	10

Please describe how you are most functionally limited by this injury (circle):

Lifting/ Carrying Moving/ Changing Positions Walking Self-care/ Household activities

How functionally limited are you with these activities due to this episode/Injury (circle):

10% 20% 30% 40 % 50% 60% 70% 80% 90% 100%

Patient/ Guardian Signature:____ **Date:**________________