Hodgson Physical Therapy & Pilates

MEDICAL HISTORY QUESTIONNAIRE (*PLEASE PRINT*)

PATIENT LAST NAME	FIRST	MI

DATE OF ONSET OF INJURY/CONDITION:	FAMILY PHYSICIAN	REFERRING PHYSICIAN
HAVE YOU EVER HAD SURGERY FOR THIS INJURY? O YES O NO	IF YES, TYPE OF SURGERY:	DATE OF SURGERY:

HAVE YOU HAD PREVIOUS PHYSICAL THERAPY FOR THIS CONDITION? O YES O NO

DO YOU SMOKE? O YES O NO | ARE YOU PREGNANT OR THINK YOU MIGHT BE PREGNANT? O YES O NO

HOW HAS YOUR INJURY AFFECTED YOU EMOTIONALLY?
O DEPRESSION O WITHDRAWAL O ANGER O ANXIETY O NONE O OTHER, PLEASE LIST:

WHAT IS THE SEVERITY OF YOUR EMOTIONAL REACTION? SCALE OF 1(LOW) - 10(HIGH) | WHO IS YOUR FAMILY/COMMUNITY SUPPORT?

LIST ALL MEDICATION (S) YOU ARE ALLERGIC TO:

DO YOU HAVE ANY SENSITIVITY TO LATEX THAT YOU ARE AWARE OF? O YES O NO

LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING, EITHER PRESCRIPTION OR NON-PRESCRIPTION:

PLEASE LIST ANY OTHER HEALTH CARE PROFESSIONALS WHOSE CARE YOU ARE CURRENTLY UNDER FOR THIS CONDITION:

IS THERE ANY OTHER INFORMATION THAT WOULD ASSIST US WITH YOUR CARE?

WHAT ARE YOUR GOALS /EXPECTATIONS FROM PHYSICAL THERAPY OR PILATES?

HAVE YOU EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS?

YES	NO	
O	O	Cancer
O	O	Chest Pain or Shortness of Breath
O	O	Heart Diseases
O	O	High Blood Pressure
O	O	Pacemaker
O	O	Heart Attack
O	O	Stroke or TIA
O	O	Congestive Heart Disease
O	O	Blood Clots
O	O	Circulation Problems
O	O	Seizure Disorder or Epilepsy
O	O	Thyroid Problems
O	O	Asthma, Emphysema or Bronchitis
O	O	Chemical Dependency
O	O	Diabetes
O	O	Rheumatoid Arthritis
O	O	Other Arthritis Conditions
O	O	Fibromyalgia

YES	NO	
O	O	Infectious Diseases
O	O	Hepatitis
O	O	Headaches Frequent/Severe
O	O	Hearing/Vision Difficulties
O	O	Numbness or Tingling
O	O	Dizziness
O	O	Weakness

Surgery or Injury of any of the following:

YES	NO	
O	O	Neck-Type:____________
O	O	Back-Type:____________
O	O	Shoulder-Type:_________
O	O	Elbow-type:___________
O	O	Hand-Type:___________
O	O	Hip-Type:____________
O	O	Knee-Type:___________
O	O	Ankle or Foot-Type:_____

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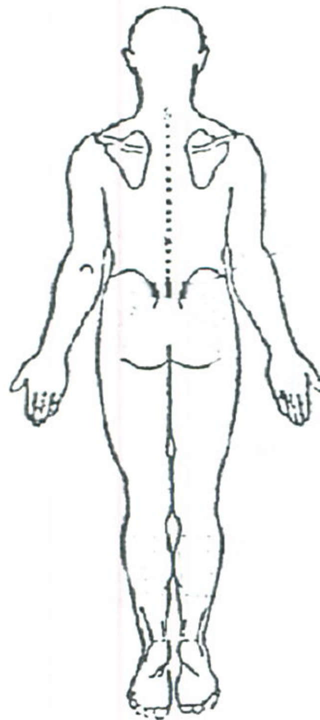
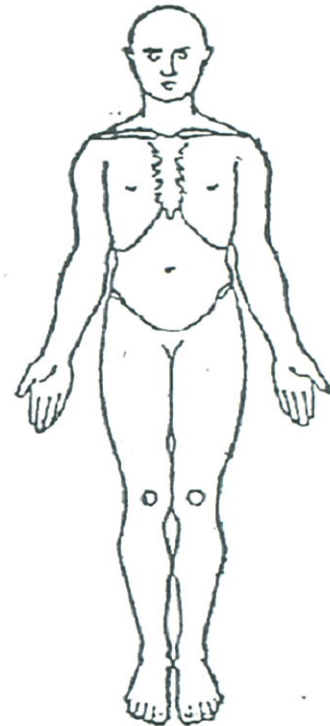
ON A SCALE OF 0 TO 10 RATE YOUR PAIN: BEST: WORST: CURRENT:
DESCRIBE THE TYPE OF PAIN YOU ARE EXPERIENCING (ACHE, BURNING, DULL, PULSING, SHARP, STABBING, STEADY, THROBBING, SHOOTING, OTHER):
WHEN DID YOU FIRST EXPERIENCE THE PAIN (MONTH/YEAR):
WHAT ACTIVITIES ALLEVIATE YOUR PAIN?
WHAT ACTIVITIES AGGRAVATE YOUR PAIN:
HAS YOUR CONDITION BEEN GETTING BETTER OR WORSE?

PLEASE MARK THE DIAGRAM
WHERE YOUR PAIN IS:





THERAPIST SIGNATURE

DATE

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