

H & D Physical Therapy Patient Medical and Physical History Questionnaire

Date:	Last Name:	First Name:	Age:	<input type="radio"/> Right-handed <input type="radio"/> Left-handed
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Present Status

What is your chief complaint?

Date of onset of injury, illness or pain requiring physical therapy:

What, if any, treatment have you had for this problem? Physical therapy Chiropractic
 Acupuncture Other _____

When was your treatment? Start Date: End Date: How many treatments did you receive?

Did this treatment help? Yes No Explain:

Have you had any special tests (MRI, x-rays, etc) and what were the results?

Are you pregnant? Yes No If yes, how many months?

Medical History

Have you been discharged from a hospital or skilled nursing facility in the last 30 days? Yes No
If yes, date of discharge: Name of hospital or skilled nursing facility:

List any past surgeries you have had:

List all medications you are presently taking:

Circle if yes:

Allergies	Diabetes	Kidney Disease
Anemia	Difficulty Walking	Obesity
Angina or Chest Pain	Difficulty Swallowing	Open Skin Sores
Arthritis or pain in a joint	Discomfort in Middle or Lower Back or Radiating to the Legs	Rheumatoid Arthritis and other conditions affecting multiple joints
Asthma	Emphysema	Osteoporosis
Cancer	Fracture	Pacemaker
Chronic Bronchitis	Headaches	Pain with coughing or sneezing
Circulatory Problems	Heart Disease	Persistent Mental Disorders
Depression	Hepatitis	Pneumonia
Depression	High Blood Pressure	Stomach Problems
Shortness of Breath	Stroke	Unexplained Weight loss or gain
Urinary Tract Infection	Vestibular (Inner Ear) Disorders	Other:

Signature: _____

Date: _____