Loudoun Sports Therapy Center™

"Don't let pain limit you. We Care. We Listen. We Get RESULTS!"

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____ **Date of birth:** _____

Please take a moment to answer these questions so that your Physical Therapist may address your concerns more easily and efficiently during your evaluation with us.

Have you ever been diagnosed with or are you Experiencing issues related to any of the following:

[ ] Diabetes
[ ] High Blood Pressure
[ ] Heart Disease
[ ] High Cholesterol
[ ] Osteoporosis
[ ] Blood Clot
[ ] Fracture
[ ] sprains / strains
[ ] Shortness of Breath
[ ] Sleeping problems
[ ] HIV / AIDS
[ ] Hepatitis
[ ] MRSA
[ ] Pneumonia
[ ] Allergy to
  [ ] latex
  [ ] adhesives
  [ ] medications: _____
[ ] Arthritis (Rheumatoid or Osteoarthritis)
[ ] Headaches how often? _____
[ ] Stroke when? _____
[ ] Bowel / Bladder Problems
[ ] Cancer type: _____
[ ] other: _____

In the past six months have you had or did you experience

[ ] Headaches
[ ] numbness or tingling
[ ] Change in your health
[ ] Dizziness
[ ] loss of balance
[ ] Urinary Tract Infection
[ ] Bowel or Bladder changes

Are you currently pregnant or considering pregnancy in the next two months?

[ ] Yes [ ] No

In the past two weeks are your symptoms (choose one)

[ ] getting worse
[ ] staying the same
[ ] improving

Does the condition that brought you here today effect (check all that apply)

[ ] your ability to sleep comfortably
[ ] your ability to work effectively
[ ] your ability to participate in leisure activities of your choosing. Please list those here:

_____

_____

[ ] other: _____

Have you

[ ] fallen 2 or more times in the past year
[ ] had surgery of any kind at any time in the past. If so, what type and when:

_____

Are you currently taking any medications for this or any other medical condition? If so, please list them here (please use additional space on back if needed)

_____

_____

_____

In the past year, have you been seen by a Physical Therapist or Chiropractor for this or <u>any other condition</u>? If so, please describe briefly:

_____

_____

<u>PLEASE FLIP THIS PAGE OVER FOR ADDITIONAL INFORMATION</u>

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What date or approximate date would you say your symptoms or pain began?

_____

How would you describe your pain or symptoms at this time (check all that apply:

[ ] sharp pain
[ ] dull pain
[ ] achey
[ ] tight
[ ] sore
[ ] weakness
[ ] loss of function or ability to do things during the day
Please list those things:

_____
_____
[ ] other: _____
_____

How did your symptoms start?

_____
_____
_____
_____

How often do you experience your symptoms or pain?

[ ] constantly (76% to 100% of the time)
[ ] frequently (51% to 76% of the time)
[ ] occasionally (up to 51% of the time)

How much do your symptoms interfere with your daily activities (including sleep)?

[ ] a little bit
[ ] moderately
[ ] quite a bit
[ ] extremely

In general, how would you rate your overall health right now?

[ ] excellent
[ ] very good
[ ] good
[ ] fair
[ ] poor

What is the reason that you chose to seek care for this condition?

_____
_____
_____

Please use this space below to provide us with any additional information you feel would be helpful or useful to us in the course of treating you for this condition.

_____
_____
_____
_____
_____

Thank you for taking the time to complete this questionnaire out. It truly is our goal to care and listen to your needs and thus be able to help you to improve your condition and achieve the RESULTS you are looking for. We look forward to working with you now and in the future.