**H & D Physical Therapy**
**Patient Medical and Physical History Questionnaire**

| Date: | Last Name: | First Name: | Age: | O Right-handed<br>O Left-handed |
|---|---|---|---|---|

## 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? O Physical therapy O Chiropractic
O Acupuncture O Other _____

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

Did this treatment help? O Yes O No Explain:

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

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

## Medical History

Have you been discharged from a hospital or skilled nursing facility in the last 30 days? O Yes O 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: _____