Premier Physical Therapy Services Medical History /Questionnaire **Today's Date**_____

To Be Completed by the patient or guardian – Please Print

Name_____ **SS #**_____ **Date of Birth**_____

Age _____ **Height** _____ **Weight** _____ **Referring Physician** _____

How did you hear about us?: ☐ **Dr.** _____ ☐ **Self-Referral** ☐ **Radio** ☐ **Social Media** ☐ **Friend**

Other:_____ **(Check all that apply)**

Chief Complaints: (What problems are you having?)

_____

_____

Do you smoke? Y N If so, how many packs/day?_____ **Do you drink? Y N How much**_____

Do you have any drug allergies: Please specify _____

Please list your current medications _____

_____

Do you see a doctor on a regular basis for any medical problems? If so, please list them _____

_____

Have you been in contact or exposed to any blood borne pathogens such as HIV/Aids, Hepatitis A/B etc. or other communicable disease such as Tuberculosis? If so, please explain_____

Have you had physical therapy or chiropractic treatment this year? Y N If yes, where:_____

Have you ever had the following (circle yes or no, leave blank if uncertain)

Anemia	Y N	Heart disease	Y N	Stroke	Y N
Arteriosclerosis	Y N	Hernia	Y N	Thyroid Disease	Y N
Arthritis	Y N	High or Low Blood Pressure	Y N	Please list any other disease or comments:	
Asthma/Emphysema	Y N	Kidney Disease	Y N	_____	
Back Trouble	Y N	Metal Implants	Y N	_____	
Bleeding Tendency	Y N	Migraines	Y N	_____	
Blood Clots	Y N	Mitral Valve Prolapse	Y N	_____	
Circulatory Condition	Y N	Pacemaker	Y N	_____	
Diabetes	Y N	Phlebitis	Y N	_____	
Dizziness or Fainting Spells	Y N	Pneumonia	Y N	_____	
Epilepsy	Y N	Skin Disease/Rashes	Y N		

Previous surgeries (Please state the year and what illness/surgery you had)

Date/Year	Illness/Operation	Date/Year	Illness/Operation

My signature below confirms that this medical history is accurate to the best of my knowledge:

_____ _____

(Patient or guardian signature) **(Date)**

rev. KMW 2/12

Pain and Symptoms (Circle the best possible answer):

Is your pain? Occasional Continuous Constant Intermittent Unrelenting

Symptom trend: Condition improving Condition worsening Condition unchanging

When is your pain the worst? Morning Afternoon Evening Nighttime

When is your pain the best? Morning Afternoon Evening Nighttime

Does the pain affect your sleep? YES NO

Circle the number the rates your pain *right now*:

None 1 2 3 4 5 6 7 8 9 10 Go to the hospital

Circle the number that rates your pain *at worst*:

None 1 2 3 4 5 6 7 8 9 10 Go to the hospital

Circle the number that rates your pain *at best*:

None 1 2 3 4 5 6 7 8 9 10 Go to the hospital

Please describe:
What makes your pain better?

_____

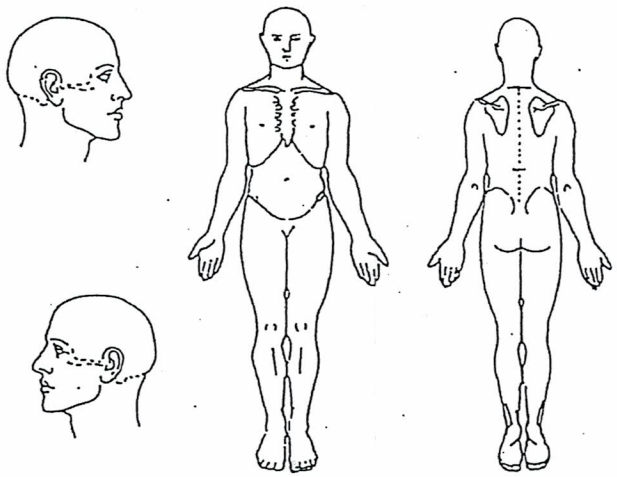
What makes your pain worse?

_____

Due to my symptoms/disease I am unable to/have difficulty with _____

My goal(s) for therapy: _____

Please indicate below where your symptoms are located



KEY	
Numbness	= = = = = =
Pins & Needles	*******
Burning Pain	BBBBBBB
Stabbing Pain	///////
Shooting Pain	XXXXXXX
Achy Pain	AAAAAAA

My signature below confirms that this medical history is accurate to the best of my knowledge:

_____ _____

(Patient or guardian signature) **(Date)** **rev. ANM 4/13**