QUINNIPIAC PHYSICAL THERAPY AND SPORTS MEDICINE, P.C.

PHYSICAL MEDICINE AND REHABILITATION MEDICAL HISTORY

NAME:______________________________ DATE:______________________

OCCUPATION:____

1. What are your present symptoms and when did they start?
____
____
____
____
____

2. Do you have pain, tingling or numbness? (circle appropriate answers)

   On a scale of 1 – 10 with 10 being excruciating pain, how would you rate your pain? (circle one)

   1 2 3 4 5 6 7 8 9 10

3. How would you describe it?

   (Sharp, dull, throbbing, burning, aching, constant, intermittent, etc.)
____

4. What makes your pain better?
____

   What makes your pain worse?
____

5. Are you currently taking any medications?______________________

   If yes, please list ______________________________

6. Are you allergic to any medication or chemicals?______________________

   If yes, please list______________________________

7. Have you recently had a x-ray or other diagnostic test?

   If yes, please list tests and where they were done
____
____

8. What kind of surgeries have you had? (please list)
____
____

9. Do you have any other medical conditions we should be aware of?

   (Diabetes, heart problems, pacemaker, etc.?)
____
____

10. Have you received physical therapy before?
    If yes, please list when and where______________________________

11. Are you pregnant?______________________________

12. Any other comments problems?______________________________