**Patient Questionnaire and Medical History Form*

Physical Therapy Evaluation- Patient Questionnaire

Why were you referred to Back in Motion Physical Therapy?

Please describe the history of your current condition: _______________

____

____

What goals would you like to achieve? ____________________________

Where is your pain? (Mark the body diagram attached) ____________

On a pain scale of 0-10, (0 = no pain & 10= call 911), what is your present level of pain?

____

Is your sleep interrupted by pain? Yes____ No_____

What activities or positions worsen your pain? ______________

____

What activities or positions lessen your pain? _______________

____

Medical History:

General Health (check one): ___ Excellent ___ Good ___ Fair ___ Poor

Please list any recent medical problems or hospitalization in the past year:

____

____

____

List all past medical problems: _________________________________

X-ray/MRI/Lab result: ____

Prescription Medications: ______________________________________

____

Height ____________________ Weight ___________________________

Do you smoke? Y N amt. __________ Alcohol Y N amt.____________

Caffeine Y N # cups/day ______________

During the past month have you felt down, depressed or hopeless? ____

During the past month have you lost interest or pleasure in doing things? ____ Is this something with which you would like help? _____

<u>Present/Past Medical Conditions:</u>

Asthmas Y N Heart Attack Y N
Arthritis Y N Heart Disease Y N

Cancer Y N Hepatitis Y N

Circulatory Disease Y N High Blood Pressure Y N

Depression Y N Kidney Disease Y N

Dizziness Y N Multiple sclerosis Y N

Headaches Y N Numbness Y N

Emphysema Y N Osteoporosis Y N

Fainting Y N Pregnancy Y N

Fever/Chills Y N Stroke Y N

Thyroid Problems Y N Balance Problems Y N Weakness Y N Constipation Y N

Do you have Diabetes Y N Parent with Diabetes Y N Gave birth to baby 9lb or >Y N Sister/brother Diabetes Y N

Do you leak urine when you cough/sneeze, laugh or exercise? Y N

Do you leak urine when you have a strong urge to urinate? Y N

Do you exercise regularly? Yes/No if yes _____/week _______min. /day.

What type of exercise do you perform? ____________________________

Do you know that regular exercise 3 or more times a week can reduce your risk of developing:

Diabetes

Cancer

Alzheimer's Disease

Depression

High Blood Pressure

Cardiovascular Disease

Where is your pain?

Please mark on the drawings below the areas where you feel your pain.

Mark with an "X"