WILDERMAN PHYSICAL THERAPY, LLC
MEDICAL HISTORY QUESTIONNAIRE

Patient name:_____ Date:_____

Date of Birth/Age:_____/_____ Are you presently working? Yes___No___

Referring Physician (if applicable):_____ Family Physician:_____
Date of injury/onset:_____ Have you ever had these symptoms before? Yes___No___
Check all that apply to your symptoms:
_____Work related injury _____Recurrence of previous injury _____Motor vehicle accident
_____Injury related to lifting _____Athletic/recreational injury _____Injury related to falling
_____Cause unknown _____Other(please specify):_____

Date last worked to this injury:_____ Date returned to work after this injury_____

On a scale from 0 (no pain) to 10 (most severe pain) rate your pain level:
Best/Lowest_____/10 Right Now_____/10 Worst/most_____/10

My pain can be described as (check all that apply):___Constant ___Intermittent ___Sharp ___Dull
___Aching ___Stabbing ___Numbness ___Pins/Needles

Have you had any of the following Medical or Rehabilitative Care for this injury/episode?
If yes, when?_____

	YES	NO		YES	NO		YES	NO
Chiropractor	___	___	Neurologist	___	___	X-Rays	___	___
General practitioner	___	___	Orthopaedist	___	___	MRI	___	___
Physical Therapy	___	___	Podiatrist	___	___	CT Scan	___	___
Occupational Therapy	___	___	ER Care	___	___	Myelogram	___	___
Home Health Service	___	___	Massage Therapy	___	___	EMG/NCV	___	___

Have you ever had surgery related to this condition? ___YES ___NO
Do you have any of the following?

	YES	NO		YES	NO		YES	NO
Diabetes	___	___	Allergies	___	___	Seizures	___	___
Chest pain/Angina	___	___	Hypothyroid	___	___	Osteoporosis	___	___
High Blood Pressure	___	___	Hyperthyroid	___	___	Hernia	___	___
Heart Attack	___	___	Stroke (CVA)/TIA	___	___	Headaches	___	___
Heart Palpitations	___	___	Liver/gallbladder problems	___	___	Recent Fractures	___	___
Heart Disease	___	___	Kidney problems	___	___	Surgeries	___	___
Blood clot/Emboli	___	___	Bowel/bladder abnormalities	___	___	Metal Implants	___	___
Pacemaker	___	___	Sleeping difficulty	___	___	Urine leakage	___	___
Dizziness/Fainting	___	___	Cancer	___	___	Women Only:		
Joint Replacement	___	___	Infectious Diseases	___	___	Pregnant	___	___
Rheumatoid Arthritis	___	___	Hearing/vision difficulty	___	___	Endometriosis	___	__
Osteoarthritis	___	___	Asthma/Breathing difficulties	___	___	Pelvic Inflam. Disease	___	___
Multiple Sclerosis	___	___	Weight Loss	___	___	Irreg. Menstrual Cycle	___	___
Parkinson's Disease	___	___	Energy Loss	___	___	Complicated pregnancies	__	__

If YES to any of the above, please briefly explain and give approximate dates:

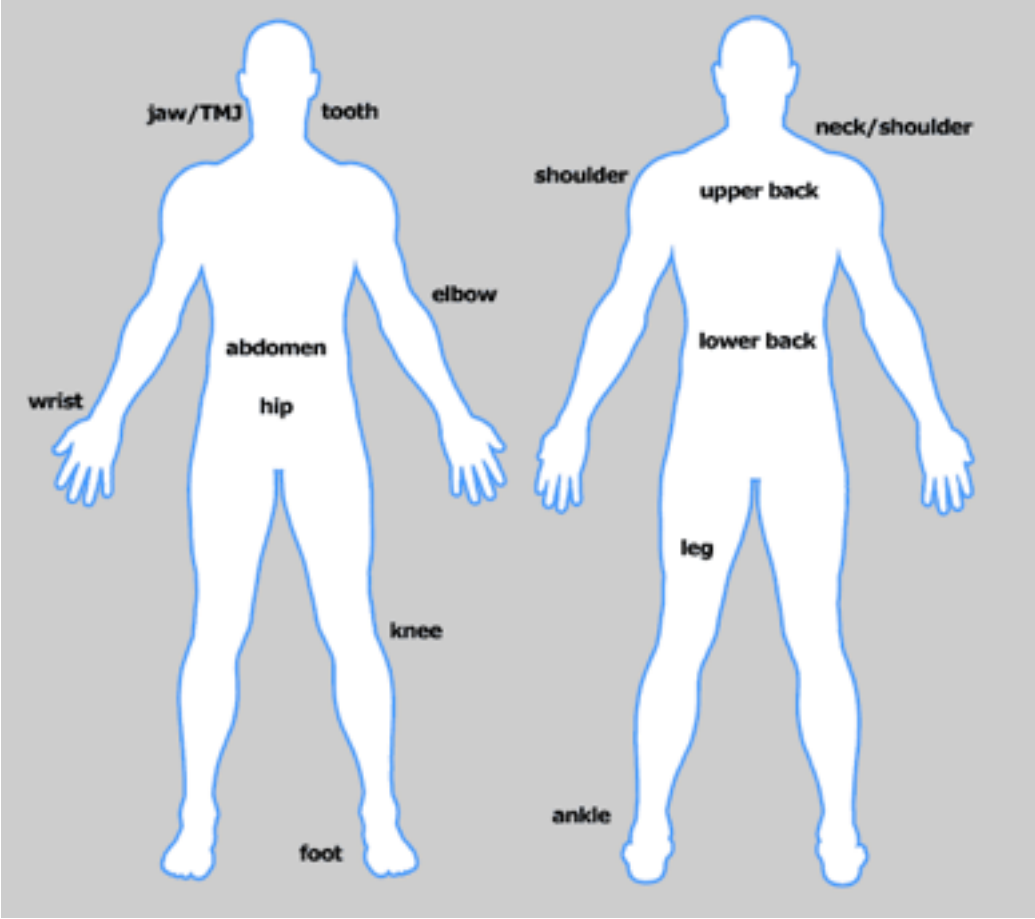
_____
_____
_____
_____

Are you currently taking medication? ___YES ___NO
(If YES, please list medication and for what condition):

_____
_____
_____
_____

PLEASE COLOR YOUR AREA OF PAIN ON THE BODY DIAGRAM BELOW

FRONT



BACK

What goals would you like to achieve through Physical Therapy?

_____
_____
_____
_____

I certify that the information provided on my Medical History has been provided as accurately as possible.

Patient/Guardian Signature_____Date:_____