

WILDERMAN AND ASSOCIATES PHYSICAL THERAPY, PC
MEDICAL HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to help us understand your health status. Please complete this form and your therapist will answer any questions during your exam. This form is considered part of your medical record.

Patient Name: _____ Date _____

D.O.B./Age _____/_____ Are you presently working? Yes No

Date of next referring physician appointment _____

Referring Physician _____ Family Physician _____

Date of injury/onset _____ Have you ever had these symptoms before? Yes No

Check all that apply to your symptoms:

- | | | |
|--|--|--|
| <input type="checkbox"/> Work related injury | <input type="checkbox"/> Recurrence of previous injury | <input type="checkbox"/> Motor Vehicle accident |
| <input type="checkbox"/> Injury related to lifting | <input type="checkbox"/> Athletic/recreational injury | <input type="checkbox"/> Injury related to falling |
| <input type="checkbox"/> Cause unknown | <input type="checkbox"/> Other _____ | |

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

Pain (please draw a vertical line where you would rate pain intensity) 0-----5-----10

My pain can be described as (circle 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 | ___ | ___ | CT Scan | ___ | ___ | Neurologist | ___ | ___ |
| General Practitioner | ___ | ___ | EMG/NCV | ___ | ___ | ER care | ___ | ___ |
| Occupational Therapy | ___ | ___ | MRI | ___ | ___ | Orthopedist | ___ | ___ |
| Physical Therapy | ___ | ___ | Myelogram | ___ | ___ | Podiatrist | ___ | ___ |
| Home Health Svc. | ___ | ___ | X-rays | ___ | ___ | Massage Therapy | ___ | ___ |

Have you ever had a surgery related to this condition? YES NO

Do you have any of the following:

| | YES | NO | | YES | NO | | YES | NO |
|----------------------|-----|-----|-------------------------------|-----|-----|------------------|-----|-----|
| Diabetes | ___ | ___ | Allergies to Aspirin | ___ | ___ | Surgeries | ___ | ___ |
| Chest Pain/Angina | ___ | ___ | Allergies to Heat | ___ | ___ | Cancer | ___ | ___ |
| High Blood Pressure | ___ | ___ | Heart Disease | ___ | ___ | Recent Fractures | ___ | ___ |
| Other Allergies | ___ | ___ | Thyroid trouble/Goiter | ___ | ___ | Hypoglycemia | ___ | ___ |
| Heart Attack | ___ | ___ | Sleeping Problems/difficulty | ___ | ___ | Osteoporosis | ___ | ___ |
| Heart Palpitations | ___ | ___ | Liver/gallbladder problems | ___ | ___ | Hernia | ___ | ___ |
| Blood clot/Emboli | ___ | ___ | Stroke/TIA | ___ | ___ | Seizures | ___ | ___ |
| Pacemaker | ___ | ___ | Intolerance to cold | ___ | ___ | Metal Implants | ___ | ___ |
| Dizziness/Fainting | ___ | ___ | Kidney Problems | ___ | ___ | Headaches | ___ | ___ |
| Joint Replacement | ___ | ___ | Infectious Diseases | ___ | ___ | Urine leakage | ___ | ___ |
| Rheumatoid Arthritis | ___ | ___ | Bowel/bladder abnormalities | ___ | ___ | Incontinence | ___ | ___ |
| Numbness/Tingling | ___ | ___ | Hearing or vision difficulty | ___ | ___ | Parkinson's | ___ | ___ |
| Multiple Sclerosis | ___ | ___ | Asthma/breathing difficulties | ___ | ___ | | | |
| Skin Abnormalities | ___ | ___ | Weight or energy loss | ___ | ___ | | | |

Women Only:

| | | | | | | | | |
|-------------------------|-----|-----|-----------------------------|-----|-----|----------|-----|-----|
| Endometriosis | ___ | ___ | Pelvic Inflammatory disease | ___ | ___ | Pregnant | ___ | ___ |
| Complicated pregnancies | ___ | ___ | Irregular Menstrual cycle | ___ | ___ | | | |

If yes on any of the above, please briefly explain and give approximate date:

Are you presently taking medication? Yes No If yes, please list medication and for what condition.

Patient/Guardian Signature: _____ Date _____