SUMMIT HEALTH
PHYSICAL THERAPY

Medical Questionnaire

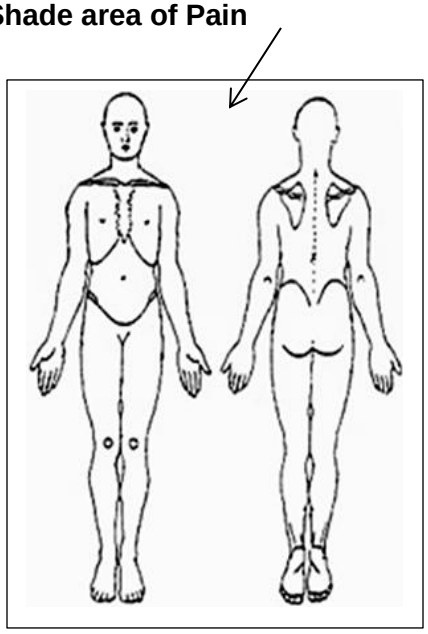
Name: _____ DOB: _____ Height: _____ Weight: _____

What are your symptoms and when did they start: _____

_____

Describe how your condition or injury occurred: ☐ Work ☐ Sports Injury ☐ Auto Accident
☐ Other _____

Shade area of Pain



Side of injury: ☐Right ☐Left

Please rate your pain on the scale below of 0 to 10:
(0 = no pain; 10 = worst pain imaginable/emergency room pain)
Pain at rest: _____ Pain with activity: _____

Does your pain wake you at night: ☐ Yes ☐ No

What eases your symptoms: _____

_____

What aggravates your symptoms: _____

_____

Have you had any previous treatment: _____

_____

Have you had any of the following: ☐X-rays ☐ MRI ☐ CT Scan
☐Other: _____

Are you currently working: ☐ No ☐ Yes ☐Full-time ☐ Part-time ☐ Restricted

What activities at home, work or recreational are you unable to perform: _____

What goals do you hope to accomplish with Physical Therapy: _____

Referring Physician:_____Returning to Physician:_____

How did you hear about us: _____

Medical History (check all that apply)

☐ Cancer_(TYPE)_____ ☐ Breathing Difficulties ☐Diabetes

☐ High Blood Pressure ☐ Joint Replacement ☐Heart Disease ☐History of seizures

☐ Recent Surgery ☐ Bone & Joint disorders ☐Pacemaker Are you pregnant ☐ Yes ☐ No

Other Past Medical History or surgeries: _____

_____

Medications: _____

_____

Signature: _____ Date: _____