PIVOT PHYSICAL THERAPY

Patient Questionnaire/Medical History Form

Under Medicare and the State practice acts, we are required to obtain a complete medical history on all patients. This information is protected under HIPAA laws. Please answer all questions to the best of your ability.

Last Name: ______________________________ **First Name:** ____________________________ **MI:**____ Date:___/___/______

DOB: ___/__/____ Age: _______Sex: M / F Hand Dominance: R / L Height:___________ Weight: ________________

How did you hear about us? ____

Primary Care Doctor: ___________________________________Referring Doctor: _________________________________

If accident, circle place where occurred: Home Auto Work Sports Other Next Doctor's Visit: ____/___/___

Occupation:________________Work involved? _________________________________ Current Work Status: ____________

Do you have any lifting restrictions? Y / N Do you live alone? Y / N Are there stairs where you live? Y / N

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What is the reason for your visit today? ____

Briefly describe how your problem began: ____

What goals would you like to achieve through therapy? ____

Date of onset/injury:___ /___/_____ Date of surgery: ___/___/___ Type of Surgery: _____________________________

Prior or ongoing treatments for your current chief complaint include: (Circle all that apply) ☐ No treatment received yet

Physical Therapy	Chiropractic Care	Pain management	Mechanical Traction
Massage	Injections	Aquatic Therapy	Brace/Tape
Surgical Intervention	Personal Training	Athletic Training	Other: _____________________

Have any diagnostic tests been performed for this problem? (Circle all that apply)

X-rays Bone Scan Doppler Ultrasound MRI EMG CT Scan Blood work Other:_________________

Please list body part tested and date tested: ____

Have you had similar symptoms in the past? Y / N Have you received Home Health PT prior to coming here? Y / N

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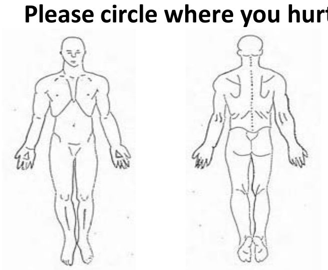
Please circle where you hurt:



Where did your pain start? ____

Since it started, pain is: ☐ getting worse ☐ improving ☐ the same

Describe pain: ☐ sharp ☐ dull ☐ aching ☐ sore ☐ throbbing ☐ cramping ☐ burning ☐ shooting ☐ stabbing ☐ squeezing ☐ constant ☐ intermittent

☐ Other:____

What makes it worse?____

What makes it better? ____

Does time of day affect pain? ______________________________________

Does pain wake you from sleep?_____________________________________

Please rate your pain on 0-10 scale (0 is no pain, 10 is the worst you can imagine):

Least: 0 1 2 3 4 5 6 7 8 9 10 Worst: 0 1 2 3 4 5 6 7 8 9 10 Present: 0 1 2 3 4 5 6 7 8 9 10

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Do you have any tingling, numbness or loss of sensation? Y / N If so, where? ___________________________________

Do you have any weakness? Y / N If so, for how long? ____

Do you have any swelling? Y / N If so, where? ____
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Have you fallen *two (2) or more times* within the past 12 months? Y / N

Have you sustained an injury as a result of these falls? Y / N

Do you use any of the following: Cane Walker Crutches Wheelchair

How would you rate your current health? ☐ excellent ☐ very good ☐ good ☐ fair ☐ poor

Please circle yes or no if you have or have had any of the following conditions:

	Yes / No		Yes / No		Yes / No
High Blood Pressure	Y / N	Diabetes	Y / N	Osteoarthritis	Y / N
High Cholesterol	Y / N	Heart Attack	Y / N	Rheumatoid Arthritis	Y / N
Bowel/Bladder Dysfunction	Y / N	Cardiac Bypass	Y / N	Osteoporois or Osteopenia	Y / N
Acid Reflux or Ulcers	Y / N	Cardiac Stents	Y / N	Scoliosis	Y / N
Thyroid disorder	Y / N	Angina/Chest Pain	Y / N	Headaches or Migraines	Y / N
Bleeding disorder	Y / N	Hepatitis	Y / N	Dizziness or Fainting	Y / N
Seizures/Epilepsy	Y / N	Emphysema	Y / N	Cancer (site:)	Y / N
Lyme Disease	Y / N	COPD	Y / N	Recent Infection	Y / N
Currently pregnant-#wks _	Y / N	Asthma	Y / N	Multiple Sclerosis	Y / N
Fibromyalgia	Y / N	Kidney Disease	Y / N	Congestive Heart Failure	Y / N
Lupus	Y / N	Stroke	Y / N	Depression	Y / N

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**Please circle any that you may have and/or wear: Glasses Contacts Dentures Pacemaker Metal Implant Hearing Aides

**Please circle any of the following that may apply:

Mental Disorder: (Type)______ Dementia/Alzheimer HIV/AIDS Parkinson's Hepatitis (Type):_______

Are you a tobacco user? Y / N

List all previous surgeries and dates (in the last 5 years):

___

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___

List all medications/supplements you are taking including dosage and frequency (use additional page if needed) :

___

___

___

List all allergies that you may have: ______________________________

Who should we call in case of an emergency?

Name ______________________________ Relation ___________________________ Phone ______________________________

To the best of my ability, I have given and included all pertinent medical information.

Patient/Guardian signature: ____ Date:___/___/_______

Medical history reviewed by physical therapist and used in determining the plan of care.

Therapist signature: ____ Date:___/____/______
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