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:_____ Pronoun:_____

Hand Dominance: ❑ R ❑ L Height: _____ Weight: _____

How did you hear about us? _____

Primary Care Doctor:_____ Referring Doctor: _____

If accident, check 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

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: *(check all that apply)*

❑ Physical Therapy	❑ Chiropractic Care	❑ Pain Management	❑ No treatment received yet
❑ Massage Therapy	❑ Injections	❑ Aquatic Therapy	❑ Mechanical Traction
❑ Surgical Intervention	❑ Personal Training	❑ Athletic Training	❑ Brace/Tape
			❑ Other: _____

Have any diagnostic tests been performed for this problem? *(check 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 physical therapy prior to coming here? ❑ Y ❑ N

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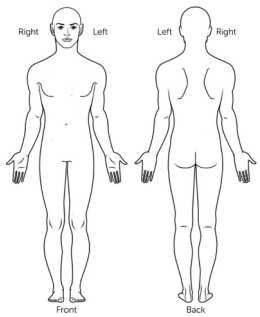
Please circle where you hurt:



Where did your pain start? _____

Since it started, the 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 a scale of 1-10 with 1 being no pain and 10 the worst pain you can imagine:

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

Do you have tingling, numbness, or loss of sensation? ❑ Y ❑ N If so, where? _____

Do you have weakness? ❑ Y ❑ N Is so, for how long? _____

Do you have swelling? ❑ Y ❑ N Is so, where? _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Give answers as 0 to 3, using this scale:
0=Not at all; 1=Several days; 2=More than half the days; 3=Nearly every day

1. Little interest or pleasure in doing things ❑ 0 ❑ 1 ❑ 2 ❑ 3
2. Feeling down, depressed, or hopeless ❑ 0 ❑ 1 ❑ 2 ❑ 3

Please complete this section if you are 65 years of age or older:

Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals? ❑ Y ❑ N

Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides, or medical care or from being with people you wanted to be with? ❑ Y ❑ N

Have you been upset because someone talked to you in a way that made you feel shamed or threatened? ❑ Y ❑ N

Has anyone tried to force you to sign papers or to use your money against your will? ❑ Y ❑ N

Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically? ❑ Y ❑ N

Best answer over the past year:

Do you use tobacco? ❑ Y ❑ N # of packs per day:_____

Do you wear glasses or contacts? ❑ Y ❑ N

Do you wear dentures or hearing aide? ❑ Y ❑ N

Do you have a pacemaker? ❑ Y ❑ N

Do you have metal implants? ❑ Y ❑ N

Do you use a cane or crutches? ❑ Y ❑ N

Do you use walker or wheelchair? ❑ Y ❑ N

Have you fallen two or more times? ❑ Y ❑ N

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

How would you rate your overall Health?

❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

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Please choose Y (yes) or N (no) if you have had any of the following conditions:

High Blood Pressure	❑ Y	❑ N
High Cholesterol	❑ Y	❑ N
Bowel/Bladder Dysfunction	❑ Y	❑ N
Acid Reflux/Ulcers	❑ Y	❑ N
Thyroid Disorder	❑ Y	❑ N
Bleeding Disorder	❑ Y	❑ N
HIV/AIDS	❑ Y	❑ N
Mental Disorder	❑ Y	❑ N
Type:_____		
Seizures/Epilepsy	❑ Y	❑ N
Lyme Disease	❑ Y	❑ N
Congestive Heart Failure	❑ Y	❑ N
Currently Pregnant	❑ Y	❑ N
# of weeks:_____		
Diabetes	❑ Y	❑ N
Heart Attack	❑ Y	❑ N
Cardiac Bypass	❑ Y	❑ N
Cardiac Stent	❑ Y	❑ N
Chest Pain	❑ Y	❑ N
Hepatitis	❑ Y	❑ N
Parkinson's Disease	❑ Y	❑ N
COPD/Asthma	❑ Y	❑ N
Emphysema	❑ Y	❑ N
Lupus	❑ Y	❑ N
Kidney Disease	❑ Y	❑ N
Stroke	❑ Y	❑ N
OTHER: _____		
Osteoarthritis	❑ Y	❑ N
Rheumatoid Arthritis	❑ Y	❑ N
Osteoporosis/Osteopenia	❑ Y	❑ N
Scoliosis	❑ Y	❑ N
Headaches/Migraines	❑ Y	❑ N
Dizziness/Fainting	❑ Y	❑ N
Dementia/Alzheimer's	❑ Y	❑ N
Cancer	❑ Y	❑ N
Type:_____		
Recent Infection	❑ Y	❑ N
Multiple Sclerosis	❑ Y	❑ N
Fibromyalgia	❑ Y	❑ N
Allergies	❑ Y	❑ N
Please list: _____		

Please list previous surgeries in the last five years with dates. Also include any disorders not listed above: _____

_____

_____

Please list all medications/supplements you are taking, including dosage and frequency: _____

_____

_____

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

Patient/Guardian Signature:_____ Date:_____

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

Therapist Signature:_____ Date:_____