

MEDICAL HISTORY QUESTIONNAIRE

Date: _____

Name: _____ Date of Birth: _____

Referring Physician: _____

1) *What are your current symptoms?*

2) *When and how did they begin?*

3) *Have you had previous treatment for this condition?*

Please specify:

4) *Please shade in the area of
Your current symptoms:*



5) *Do you now or have you ever had any of the following medical problems?*

Please give details where appropriate and list medications for each condition.

- _____ Asthma _____
- _____ Allergies _____
- _____ Cancer _____
- _____ Diabetes _____
- _____ Hepatitis / TB _____
- _____ High Blood Pressure _____
- _____ Heart Problems _____
- _____ Kidney Problems _____
- _____ Rheumatoid Arthritis _____
- _____ Skin Conditions _____
- _____ Stroke _____
- _____ Surgery _____
- _____ Osteoporosis / Osteopenia _____

6) *Are you currently pregnant?* Yes No _____

7) *Do you have any current infections?* Yes No _____

8) *Are you currently taking any other medications?* _____

Systems Review Completed:
comments: _____

Therapist Signature

Date

Please Turn Over and Complete Back Side

9) **Current Job:** _____ Full Time: _____ Part Time: _____

10) **Are you currently off work or have you missed work due to this condition?**

_____ No _____ Yes; How Long? _____

11) **Job Requirements**

Frequency (give % of Time):

_____ Prolonged Sitting _____

_____ Prolonged Standing _____

_____ Lifting _____ Lbs. _____

12) **What household activities / hobbies / sports are limited by your current condition?**

(i.e. Aerobics, walking, crafts, vacuuming, dusting, playing with children, etc.)

13) **Mark each position or activity according to whether it makes your current condition feel better or worse:**

Sitting	_____ Better	_____ Worse	Looking Up	_____ Better	_____ Worse
Standing	_____ Better	_____ Worse	Looking Down	_____ Better	_____ Worse
Lying Down	_____ Better	_____ Worse	Looking Right / Left	_____ Better	_____ Worse
Walking	_____ Better	_____ Worse	Reaching	_____ Better	_____ Worse
Bending	_____ Better	_____ Worse	Squatting	_____ Better	_____ Worse
Lifting	_____ Better	_____ Worse	Climbing Stairs	_____ Better	_____ Worse
Work	_____ Better	_____ Worse	Crossing your legs	_____ Better	_____ Worse
Other	_____				

14) **How much (if any) has your current condition limited your normal activity level?**

0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____
Bed Rest Normal

15) **Circle the number that best indicates your current symptoms. (If symptoms fluctuate, you can shade in a range on the scale).**

0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____
No Pain Unable to Function

16) **What are your personal goals for therapy?**

17) **Are you interested in information on any of Freedom's other services? (Please circle)**

Pilates

Massage Therapy

Personal Training

Active Release Therapy

Lymphedema Treatment

Yoga

Orthotic Fabrication

Golf for Life Program

Strengthening & Conditioning

Work Site Ergonomic Evaluation

Women's Health Services

*Osteoporosis Program

*Urinary Incontinence Program

*Breast Health / Post Mastectomy

*Pre-Natal / Post-Partum Education

*Pregnancy Massage

Patient Signature