Name:
DOB:
Age:
Chart: Date:

Physical Therapy
Medical/Functional Questionnaire

Date:_____

Patient Name: _____

Have you EVER been diagnosed as having any of the following conditions?

Cancer (kind:_____)	Yes	No	Depression	Yes	No
Epilepsy/Seizures	Yes	No	Hepatitis	Yes	No
Heart Problems/Pacemaker	Yes	No	Tuberculosis	Yes	No
Circulation Problems	Yes	No	Stroke	Yes	No
High/Low Blood Pressure	Yes	No	Anemia	Yes	No
Emphysema/Bronchitis	Yes	No	Osteoporosis	Yes	No
Diabetes	Yes	No	Pregnancy	Yes	No
Asthma	Yes	No	Chemical Dependencies	Yes	No
Arthritis	Yes	No	Other: _____		

Please describe any significant injuries, diseases or conditions you've been treated for (including fractures, dislocations, surgeries and joint replacements) and the approximate dates: _____

Do you have any allergies? (medications, foods or environmental) _____

Current Medications (including over the counter medications) _____

Describe your injury or problem (including date of onset) _____

Is this a work related problem? _____

Diagnostic Tests for current problem (X-Ray, MRI, CT scan, etc.) _____

Have you had PT for this problem in the past? If yes, when and where: _____

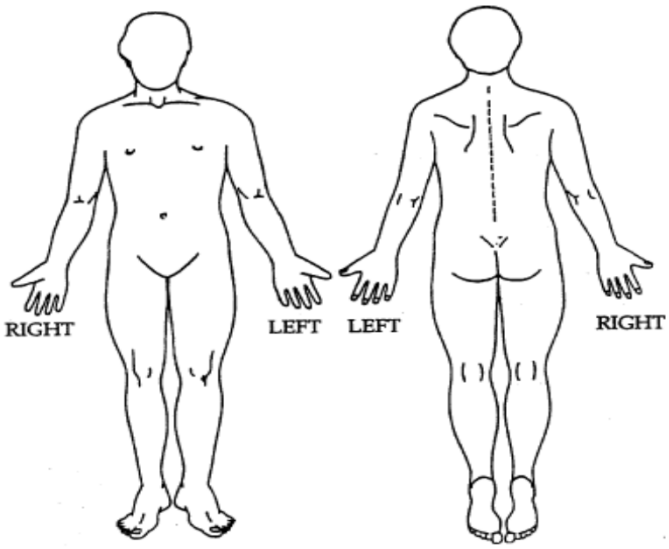
Name:
DOB:
Age:
Chart: Date:

When are you going to see your physician next? _____

Rate your CURRENT pain on a scale of 0 to 10, where 0 is no pain and 10 is the worst pain.

0 1 2 3 4 5 6 7 8 9 10

Mark on the diagram where you feel your pain.



Chief Complaints/Describe your symptoms:

_____

_____

_____

Please list any work, home or recreational activities your problem is affecting.

_____

_____

_____

_____

_____

Are there any personal goals you would like to accomplish from your time in therapy to improve your ability to do your work, home, personal care, or recreational activities?

_____

_____

_____

_____

Patient Name: _____ Patient Signature: _____
Print Name