Patient Questionnaire/Medical History Form

KSPT
Klaff Sports Physical Therapy
Feel Better.....Live Better

Under Medicare and the Maryland practice act 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?_____

Family Doctor: _____ Referring Doctor: _____

If accident, circle place where occurred: Home Auto Work Sports Other

Next Doctor's visit: ___/____/____

Occupation: _____ 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 If yes how many? _____

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:**_____

Treatments for your current chief complaint have included: (Circle all that apply)

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

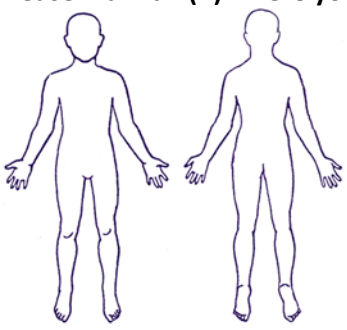
Have any diagnostic tests been performed for this problem? (circle all that apply)

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

Please mark an (X) where you hurt:



Where did your pain start? _____

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

Describe the 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 the pain? _____

Does the pain wake you from sleep?_____

Please rate your pain on 0-10 scale (0 is no pain, 10 is the worst pain 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

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

What increases this? _____ What decreases this? _____

Do you have any weakness? Y N If so, where? _____ How long has it been present?_____

Do you have any swelling? Y N If so, where? _____ How is it being managed? _____

Have you had any recent falls? Y N Do you use any of the following: Cane Walker Crutches Weelchair

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
Smoke/Chew Tobacco	Y/N	Diabetes	Y/N	Sexually Transmitted Disease	Y/N
Packs per day:_____		Heart Attack	Y/N	Osteoarthritis	Y/N
Use of illegal substances	Y/N	Cardiac Bypass	Y/N	Rheumatoid Arthritis	Y/N
Drink Alcoholic Beverages	Y/N	Cardiac Stents	Y/N	Osteoporosis or Osteopenia	Y/N
Amount per day:___		Scoliosis	Y/N	Angina/Chest Pain	Y/N
High Blood Pressure	Y/N	Hepatitis	Y/N	Headaches or Migraines	Y/N
Bowel/Bladder Dysfunction	Y/N	COPD	Y/N	Cancer (site:_____)	Y/N
High Cholesterol	Y/N	Emphysema	Y/N	Dizziness or Fainting	Y/N
Acid Reflux or Ulcers	Y/N	Asthma	Y/N	Recent Infection	Y/N
Thyroid Disorder	Y/N	Lyme Disease	Y/N	Recent Anticoagulant Meds	Y/N
Bleeding Disorder	Y/N	Depression	Y/N	Recent Antibacterial Meds	Y/N
Kidney Disease	Y/N	Lupus	Y/N	Multiple Sclerosis	Y/N
Pregnant (# wks _____)	Y/N	Fibromyalgia	Y/N	Congestive Heart Failure	Y/N

Please circle yes or no if in the past 3 months have you experienced:

	Yes/No		Yes/No
Persistent pain at night	Y/N	Change in or problems with bladder/bowel function	Y/N
Fevers, chills or night sweats	Y/N	Changes in hearing	Y/N
Unexplained weight loss	Y/N	Changes in mental status	Y/N
Unwarranted fatigue	Y/N	Frequent or severe headaches with no history of injury	Y/N
Unusual lumps or growths	Y/N	Problems with swallowing or changes in speech	Y/N
Pulsating pain anywhere in your body	Y/N	Changes in vision (blurriness or loss of sight)	Y/N
Constant and severe pain in leg or arm	Y/N	Problems with balance, coordination or falling	Y/N
Swelling without a history of injury	Y/N	Fainting spells/blackouts	Y/N
Shortness of breath	Y/N	Sudden unexplained weakness	Y/N
Frequent or severe abdominal pain	Y/N	Pain, tingling or numbness in and around your face	Y/N
Frequent nausea or vomiting	Y/N	Tingling or numbness in both of your arms or both legs	Y/N
Ringing in ears	Y/N	New moles or skin lesions	Y/N

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

List all previous surgeries and dates: _____

_____

*List all medications/supplements/vitamins/OTC (over the counter) you currently take including dosage and frequency. This MUST be completed before your evaluation:

Name:_____ Frequency _____ Dose _____

Name:_____ Frequency _____ Dose _____

Name:_____ Frequency _____ Dose _____

Name:_____ Frequency _____ Dose _____

Name:_____ Frequency _____ Dose _____

List all allergies that you may have: _____

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:___/_____/_____

*Must be completed for insurance compliance. Please use a separate sheet if you need additional space