Medical History Questionnaire

SCARBOROUGH ORTHO & SPORT
Physical Therapy

Name:_____ DOB: __/__/____

Description of current problem:

_____

_____

How did your problem begin:

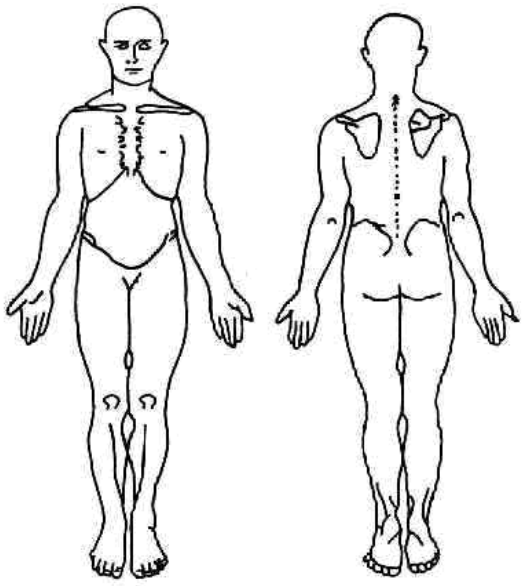
_____

_____

When did your problem begin:_____

Rate your pain: no pain 1 2 3 4 5 6 7 8 9 10 worst pain

Fill in the areas you are experiencing symptoms:



Describe your pain:

sharp dull burning ache numb/tingling

Other:_____

Pain is: Constant Intermittent

What makes your symptoms worse?

_____

_____

_____

What makes your symptoms better?

_____

_____

_____

Do you feel you are getting: better worse staying the same

Have you had this problem before? Yes No

If yes, what made it better?_____

Have you had imaging? X-Rays MRI CT scan other:_____

Medical History Questionnaire

high blood pressure	kidney disease	osteoporosis	dizziness
heart disease	diabetes	depression	vertigo
high cholesterol	cancer	anxiety	stroke
pacemaker	circulatory problem	arthritis	other:_____
lung disease	asthma	seizures	other:_____

Please list any surgeries:_____
_____

Please list any allergies:_____

Contact information:

Best phone number to reach you _____

This number will be used to contact you regarding appointments or to leave you messages that may have detailed information about your schedule or treatment.

Signature:_____

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