MOMENTUM
PHYSICAL THERAPY

Patient Questionnaire/Medical History Form

Under law, we are required to obtain complete medical history from all patients.
This information is protected under HIPPA laws. Please answer all questions to the best of your ability.

Patient Demographics

Last Name: _____ First Name: _____ MI: ____ Date: ____/_____/_____

DOB: ____/____/_____ Age: ____ Sex: M / F Hand Dominance: R / L Height: _____ Weight: _____

Primary Care Doctor: _____ Referring Doctor: _____

Occupation: _____ Circle place where injury occurred: Home Auto Work Sport Other

Injury History and Pain Assessment

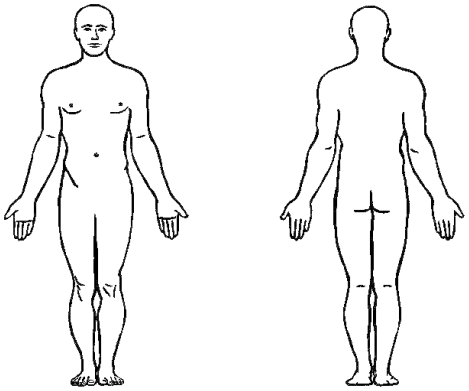
What are you coming to see us for? _____

Briefly describe how you were injured. _____

Date of Injury: ____/____/____ Date of Surgery: ____/____/____ Type of Surgery: _____

Have any diagnostic tests/imaging been performed for this problem? If so, at what facility?

_____



Please circle where you hurt.

Since the pain started, is it getting: [] worse [] better [] same

The pain is:

[] dull/ache [] sharp [] burning [] numbness

[] tingling [] constant [] intermittent [] other

Does the pain wake you from sleep? [] yes [] no

Please rate your pain on a scale of 0-10, 0 being no pain and 10 being extreme pain, in the past week. (circle)

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

Have you fallen two or more times in the past 12 months? Y / N

How would you rate your current health? Excellent Very Good Good Fair Poor

Do you have/use any of the following? Pacemaker Metal Implant

Medical History

Please circle yes or no if you have or have had any of the following conditions (Yes/No):

High Blood Pressure	Y/N	Diabetes	Y/N	Osteoarthritis	Y/N
High Cholesterol	Y/N	Heart Attack	Y/N	Rheumatoid Arthritis	Y/N
Bowel/Bladder Dysfunction	Y/N	Cardiac Bypass	Y/N	Osteoporosis/penia	Y/N
Acid Reflux or Ulcers	Y/N	Stents	Y/N	Scoliosis	Y/N
Thyroid disorder	Y/N	Chest pain	Y/N	Headaches/Migranes	Y/N
Dementia/Alzheimers	Y/N	CHF	Y/N	Dizziness/Fainting	Y/N
Bleeding disorder	Y/N	Hepatitis	Y/N	Cancer	Y/N
Seizures/Epilepsy	Y/N	Emphysema	Y/N	Recent Infection	Y/N
Lyme Disease	Y/N	COPD	Y/N	HIV/AIDS	Y/N
Currently pregnant-#wks	Y/N	Asthma	Y/N	Multiple Sclerosis	Y/N
Fibromyalgia	Y/N	Kidney Disorder	Y/N	Parkinsons	Y/N
Lupus	Y/N	Stroke	Y/N	Depression	Y/N

Are you a tobacco user? Y / N

List all previous surgeries (with dates) in the last five years.

_____

_____

List all medications/supplements you are taking including dosage and frequency (use additional page if needed).

_____

_____

List all allergies you have. _____

Who should we call in case of emergency?

Name: _____ Phone: _____

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

Patient/Guarantor signature: _____ Date: ____/____/_____

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

Therapist signature: _____ Date: ____/____/_____