AXCESS PHYSICAL THERAPY

Medical History Questionnaire

The purpose of this questionnaire is to help us understand your health status. Please complete this form and your therapists will any questions during your exam. This form is considered part of your medical record.

Name:_____ **D.O.B./Age:**_____/_____

_____

Referring Physician:_____ **Family Physician:**_____

Emergency Contact Name:_____ **Phone:**_____ **Cell:**_____

Date of Last General Check-up ____/____/____ **Occupation:** _____

Have you had surgery for this injury? **Yes** **No** **Type of Surgery/Dates:**_____

Is an Attorney involved in this Case? **Yes** **No** **Attorney Name:**_____

Please list all prescription medications you are currently taking:_____

_____

Have you had any of the following Medical or Rehabilitative Care for this Injury/Episode? If yes when?_____

	Yes	No		Yes	No
Chiropractor	____	____	CT Scan	____	____
General Practitioner	____	____	EMG/CV	____	____
Occupational Therapy	____	____	MRI	____	____
Physical Therapy	____	____	Myelogram	____	____
Massage Therapy	____	____	X-rays	____	____
Neurological	____	____	Emergency care	____	____
Orthopedist	____	____	Podiatrist	____	____

Do you now have or ever had any of the following?

	Yes	No		Yes	No
Asthma, Bronchitis, or Emphysema	____	____	Severe or Frequent Headaches	____	____
Shortness of Breath/Chest Pain	____	____	Vision or Hearing difficulty	____	____
Coronary Heart Disease or Angina	____	____	Numbness or tingling	____	____
Do you have a Pacemaker	____	____	Dizziness or Fainting	____	____
High Blood Pressure	____	____	Weakness	____	____
Heart Attack/Surgery	____	____	Weight Loss/Energy Loss	____	____
Blood Clot/Emboli	____	____	Hernia	____	____
Stroke/TIA	____	____	Epilepsy/Seizures	____	____
Allergies	____	____	Thyroid Trouble/Goiter	____	____
Pins or metal implants	____	____	Incontinence	____	____
Joint Replacement (any joint)	____	____	Bowl or Bladder Problems	____	____
Diabetes	____	____	Neck Injury/Surgery	____	____
Infectious Diseases	____	____	Shoulder Injury/Surgery	____	____
Cancer/Chemotherapy/Radiation	____	____	Elbow/Hand Injury/Surgery	____	____
Arthritis/Swollen Joints	____	____	Back Injury/Surgery	____	____
Osteoporosis	____	____	Knee Injury/Surgery	____	____
Sleeping Problems/Difficulty	____	____	Leg/Ankle/Foot Injury/Surgery	____	____
Do you smoke	____	____	Multiple Sclerosis/Parkinson's	____	____
Latex Sensitivity/Allergy	____	____			

For Women Only:	Yes	No		Yes	No
Pelvic Inflammatory Disease	____	____	Endometriosis	____	____
Irregular Menstrual Cycle	____	____	Incontinence (urinary/fecal)	____	____
Complicated pregnancies/deliveries?	____	____	Are you pregnant?	____	____

Patient/Guardian Signature:_____ **Date:**_____