

# motion hand & physical therapy

## Patient Medical History Questionnaire

Patient Name: \_\_\_\_\_

Please check any of the following whose care you are under (current and past)

Medical Doctor / D.O.  Psychiatrist / Psychologist  Dentist  Physical Therapist  Chiropractor  Other

Have you EVER been diagnosed or currently having any or the following? (Check if yes)

_____ Cancer if yes, what kind _____	_____ Hepatitis
_____ Heart Problems	_____ Chemical dependency (i.e. Alcoholism)
_____ High Blood Pressure	_____ Tuberculosis
_____ Circulation Problems	_____ Stroke
_____ Respiratory / Breathing problems	_____ Kidney Disease
_____ Diabetes	_____ Anemia
_____ Thyroid Problems	_____ Epilepsy / other seizures
_____ Multiple Sclerosis	_____ Pacemaker
_____ Rheumatoid Arthritis	_____ Headaches
_____ Other Arthritic Conditions	_____ Dizziness
_____ Osteoporosis	_____ Depression
_____ Lupus	_____ Fibromyalgia / Chronic Fatigue
_____ Hearing Aid	_____ Currently Pregnant

Please list ANY previous surgeries / procedures

Date

_____	_____
_____	_____
_____	_____

Please check below the type of medications you are currently taking

_____ Pain	_____ Anti-Inflammatory	_____ Muscle Relaxers
_____ Steroids	_____ Cardiac	_____ Blood Pressure
_____ Diabetic	_____ Antidepressant	_____ Gastro-intestine
_____ Cholesterol	_____ Allergy	_____ Blood Thinners

Other: \_\_\_\_\_

Are you allergic to any medications? Yes  No  Are you allergic to latex? Yes  No

### **-Presenting Medical Problem / Functional Status-**

How did your injury occur? \_\_\_\_\_

Injury date / First date of symptoms: \_\_\_\_\_ Surgery Date: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

Pain Rating (rate your pain on a scale of 0-10. 0=No pain and 10 = Max pain and you need to go to ER  
\_\_\_\_\_ / 10 with medication \_\_\_\_\_ / 10 without medication

What is your occupation? \_\_\_\_\_ Are you presently working? Yes \_\_\_\_\_ No \_\_\_\_\_

Job requirements: \_\_\_\_\_

Leisure Activities or Hobbies: \_\_\_\_\_

Please place a percentage in the following to describe your level of function before and after your injury

_____ Prior activities of daily living	_____ Current activities of daily living
_____ Prior recreation / sports	_____ Current recreation / sports
_____ Prior ability to perform work	_____ Current ability to perform work

Are you experiencing other limitations we should know about? \_\_\_\_\_

What is your goal for therapy? \_\_\_\_\_

Patients Signature: \_\_\_\_\_

Date \_\_\_\_\_