Chattanooga Physical Therapy

1201 Market Street, Suite A
Chattanooga, TN 37402

Patient Information:

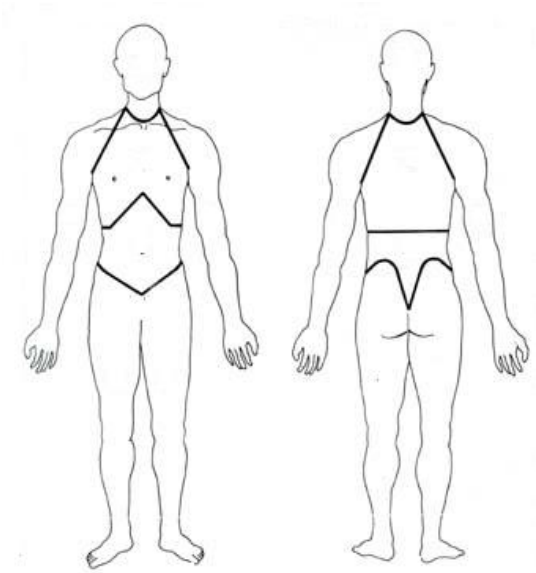
Last Name:_____ First Name:_____ MI:_____

Age_____ Weight_____ Height_____ Occupation_____

Medical History Questionnaire:

1. Where is your pain? _____

Use chart below to indicate areas of pain:



2. When did the pain start? _____

3. How did your pain start? _____

_____

4. Have you had Surgery? Yes ___ or No ___

If Yes, on what date_____

5. Is your pain (please circle): Constant or Intermittent

6. Is your pain (please circle):

sharp dull achy deep burning throbbing

Rank your pain symptoms from 0-10, 0 being none and 10 being unbearable:

On average _____ At best _____ At worst _____

7. What activities make your pain worse?_____

8. What can you do to relieve your pain? _____

9. Does your condition affect your sleep? Yes___ or No___

If Yes, can you go back to sleep? Yes___ or No___

10. How do you feel in the morning? Worse___ Better___ Stiff___ Sore___ Fine___

11. Since this problem started what tests have been done?

X-ray____ MRI____ CT Scan____ EMG____

12. Have you had anything similar to this condition?_____

13. Have you had a history of/or do you have the following: (check all which apply)

- ☐ Bursitis
- ☐ Tuberculosis
- ☐ Lung Disease
- ☐ Hernia
- ☐ Epilepsy
- ☐ Infection
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Intestinal Disorder
- ☐ High Blood Pressure
- ☐ Rheumatoid Arthritis
- ☐ Liver or Gallbladder Problems

14. Do you exercise? If yes, please describe _____

15. How often do you exercise? _____

16. In the last three months have you had any of these symptoms: (check all which apply)

- ☐ Fever
- ☐ Night Sweats
- ☐ Fatigue
- ☐ Diarrhea
- ☐ Nausea
- ☐ Dizziness
- ☐ Weight Loss
- ☐ Abdominal Pain
- ☐ Fainting
- ☐ Sweating
- ☐ Vomiting
- ☐ Shortness of Breath
- ☐ Leg Cramps
- ☐ Headaches

17. Do you have symptoms before, during or after eating? Yes___ or No___

18. Has your bowel or bladder function changed? Yes___ or No___
(i.e. pain, color, frequency)

19. Are you pregnant? Yes___ or No___

20. Have you had a joint replacement? Yes___ or No___

21. Have you been treated for cancer? Yes___ or No___

22. Do you have chest pain? Yes___ or No___

23. List all medications which you are taking:
_____
_____
_____

24. Is there anything else that you would like to add?
_____
_____
_____

_____	_____	_____
Patient Signature	Parent or Guardian Signature (If Patient is under the age of 18)	Date