STRIDE STRONG PHYSICAL THERAPY LLC

MEDICAL HISTORY QUESTIONNAIRE

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

Name: _____ Birth Date/Age: _____ / _____

Referring Physician: _____ Family Physician: _____

Emergency Contact Name: _____ Phone/Cell: _____

Occupation & Employer:_____ Currently working? _____

Have you had surgery for this injury? YES NO

Type of surgery/dates: _____

Is an attorney involved in this case? YES NO Attorney Name: _____

Are you currently taking any prescription or non-prescription medications? YES NO

Anti-Inflammatories Muscle Relaxers Pain Medicines Others: _____

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

	Yes	No		Yes	No
Chiropractor	___	___	CT Scan	___	___
General Practitioner	___	___	EMG/NCV	___	___
Occupational Therapy	___	___	MRI	___	___
Physical Therapy	___	___	Myelogram	___	___
Massage Therapy	___	___	X-Rays	___	___
Neurologist	___	___	Emergency Room Care	___	___
Orthopedist	___	___	Podiatrist	___	___

Do you now have, or have you 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)	___	___	Bowel 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	___	___
Latex Sensitivity/Allergy	___	___	Parkinson's Disease	___	___

Additional comments: _____

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: _____

PT Initials: _____ Date: _____

Patient Intake Form

Time: _____ Date: _____ Patient Name: _____

Patient phone 1: _____ Patient phone 2: _____

DOB: _____ Gender: M F

Patient address: _____

Email address: _____ How heard about us: _____

Diagnoses/problem: _____

Referring MD/physician group: _____

MD phone: _____ Rx date: _____

Onset/injury date: _____

PRIMARY INSURANCE: _____ Phone: _____

Subscriber/ID#: _____Group #:_____

Policy holder: _____ DOB: _____

SECONDARY INSURANCE: _____ Phone: _____

Subscriber/ID#: _____Group #:_____

Policy holder: _____ DOB: _____

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1) Motor Vehicle Accident / Workman's Compensation? Yes No

Name of Attorney/Case Manager: _____

Phone of Attorney/Case Manager: _____

2) Has the patient received Physical/Occupational/Speech Therapy here or at another facility previously this calendar year? Yes No
3) Has patient received HOME health PT, OT or nursing in past 30 days?
   Yes No Last Date: _____
   HOME Nursing/OT/PT Agency name:_____
   HOME Nursing/OT/PT Agency phone: _____
   D/C'ed? Yes No DC Date: _____