MEDICAL INFORMATION QUESTIONNAIRE

Please describe the **condition we are seeing you for today**. ______________________________

____

Have you received Physical Therapy for **THIS injury** before, and if so where? ______________

____

PAST MEDICAL HISTORY: (Please indicate if you have any of the following conditions)

____ Heart Disease or Heart Attack

____ High Blood Pressure

____ Tumor/Cancer

____ Osteoporosis

____ Diabetes

____ Are you pregnant?

____ Do you have a Pacemaker?

____ Do you have any surgical implants?

FUNCTIONAL PAIN SCALE:

Please rate your pain - circle the number on the scale listed below:

10- Maximum pain (emergency room pain)
9 - Very, very strong pain
8 -
7 - Very strong pain
6 -
5 - Strong pain
4 - Somewhat strong pain
3 - Moderate Pain
2 - Weak pain
1 - Very weak pain

Please (√) check all activities that cause you pain:

___ Driving
___ Walking
___ Sitting
___ Walking up stairs
___ Walking down stairs
___ Working at desk/computer
___ Vacuuming
___ Lifting
___ Sweep/mop

IN CASE OF EMERGENCY, PERSON TO BE NOTIFIED:

NAME:____________________________________**RELATIONSHIP:**____________________
LAST *FIRST*

ADDRESS:____HOME #:___________________
STREET *CITY* *STATE* *ZIP*
WORK/OTHER #:___________________

Have you received physical/occupational/speech therapy during **this calendar year**?__________
If yes, which service and where? ____

____
Signature

____
Date