

Advance Physical Therapy & Sports Rehab

1626 N. Spring St. Suite B, Beaver Dam, WI 53916
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The purpose of this questionnaire is to help us understand your health status. Please complete this form and your therapist answer any questions during your exam. This form is considered part of your medical record.

Name: _____ Date of Birth: _____ Age: _____

Referring Physician: _____ Family Physician: _____

Emergency Contact Name: _____ Phone: _____ Cell: _____

Date of Last General Health Check Up: ___/___/___ Occupation: _____

Last Date Worked Due to this Injury: ___/___/___ Date Returned to Work After This Injury: ___/___/___

Have you had surgery for this injury? Yes No

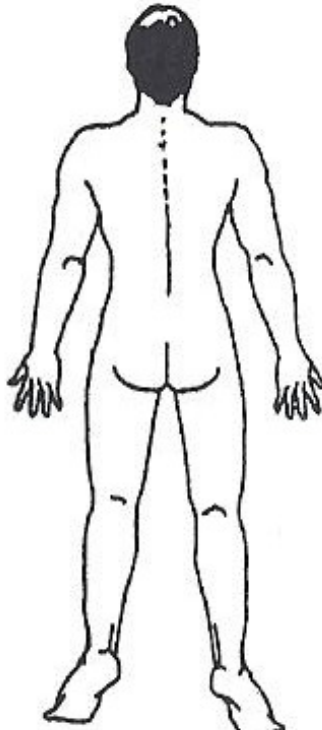
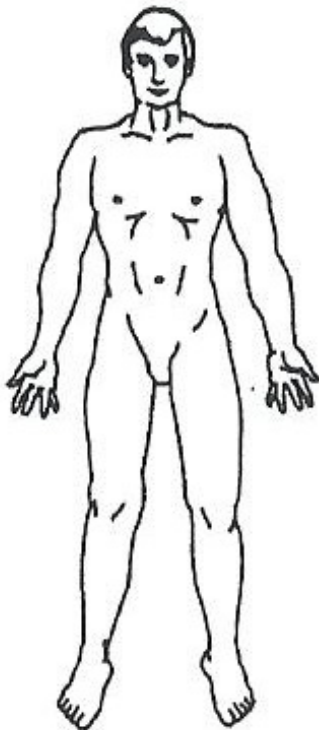
Type of Surgery/Dates: _____

Is an attorney involved in this case? Yes No Attorney Name: _____

Pain: (Please draw a vertical line where you would rate your pain intensity)

0-----5-----10
No pain Maximum pain

Please indicate the area/s where you have the pain. Please use the symbols on the right to describe the



- | | | | |
|-------|-----------|-------|----------------|
| XXX | | OOO | |
| XXXXX | - Aching | OOOOO | - Dull |
| XXX | | OOO | |
| //// | | •• | |
| ///// | - Burning | •••• | - Numbness |
| //// | | •• | |
| SSS | | +++ | |
| SSSSS | - Sharp | +++++ | - Pins/Needles |
| SSS | | +++ | |

pain.

(Please continue on to the back side.)

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? If yes, when? _____

	Yes	No		Yes	No
Chiropractor	_____	_____	CT Scan	_____	_____
General Practitioner	_____	_____	EMG/Nerve Conduction Velocity	_____	_____
Occupational Therapy	_____	_____	MRI	_____	_____
Physical Therapy	_____	_____	X-ray	_____	_____
Massage Therapy	_____	_____	Myelogram	_____	_____
Neurology	_____	_____	Emergency Room/Urgent 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/Heart Surgery	_____	_____	Weight Loss/Energy Loss	_____	_____
Blood Clot or Embolism	_____	_____	Hernia	_____	_____
Stroke/TIA	_____	_____	Epilepsy/Seizures	_____	_____
Allergies	_____	_____	Thyroid Trouble/Goiter	_____	_____
Pins or Metal Implants	_____	_____	Incontinence	_____	_____
Joint Replacement (any joint)	_____	_____	Bowel or Bladder Problems	_____	_____
Diabetes	_____	_____	Neck Injury/Surgery	_____	_____
Infectious Diseases	_____	_____	Shoulder Injury/Surgery	_____	_____
Cancer	_____	_____	Elbow/Hand Injury/Surgery	_____	_____
Chemotherapy/Radiation	_____	_____	Back Injury/Surgery	_____	_____
Arthritis/Swollen Joints	_____	_____	Knee Injury/Surgery	_____	_____
Osteoporosis	_____	_____	Leg/Ankle/Foot Injury/Surgery	_____	_____
Sleep Difficulty	_____	_____	Multiple Sclerosis/Parkinson's	_____	_____
Latex Sensitivity/Allergy	_____	_____		_____	_____

Do you smoke? Yes No If yes, how many packs/day? _____

Do you drink alcoholic beverages? Yes No If yes, how much? _____

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 ____/____/____