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Patient Medical Questionnaire

Name: | Age: | Height: | Weight: | Occupation:

Are you working now?: ◯ Yes ◯ No

Date of Injury/Onset

What are your symptoms?

1) How did the pain start? (Check all that apply)?

- ☐ Injured at work
- ☐ Auto Accident
- ☐ Sports/Recreation
- ☐ Fall
- ☐ Twisting
- ☐ Surgery
- ☐ Dental Appt.
- ☐ Unknown
- ☐ Overuse
- ☐ Lifting
- ☐ Pulling
- ☐ No Apparent Cause

2) Did the pain start ◯ Gradually ◯ Suddenly

3) Since the onset the pain has gotten:

◯ Worse ◯ Better ◯ Same

4) As the day progresses do your symptoms get:

◯ Better ◯ Worse ◯ Stay the Same

5) What other types of doctors or healtcare providers have you seen for this condition?

- ☐ Chiropractor
- ☐ Massage Therapist
- ☐ Physical Therapist
- ☐ Neurologist/ Neurosurgeon
- ☐ Orthopedic Surgeon
- ☐ Physiatrist
- ☐ Counselor/ Psychologist
- ☐ Other _____

6) Have you ever had a similar problem in the past?

◯ No ◯ Yes

Please Describe:

7) Does the pain wake you at night? ◯ No ◯ Yes

8)In what position do you sleep?:

9)Do you have pain/stiffness when you get up in the morning? ◯ No ◯ Yes

10)Do you smoke cigarettes? ◯ No ◯ Yes PPD

11)Have you ◯ gained ◯ lost **weight recently?** ◯ No ◯ Yes

12) Do you have any bowel/bladder problems? ◯ No ◯ Yes

13) Do you have problems with other joints? ◯ No ◯ Yes

14) How would you describe your general health?

15) Please list any surgeries and dates they occurred:

16) Please list all current medications:

17) Please list allergies:

18) Check all diagnostic studies you have had for this problem:

- ☐ X-rays
- ☐ Myelogram
- ☐ CT Scan
- ☐ EM
- ☐ Arthrogram
- ☐ Injections
- ☐ Bone Scan
- ☐ Bone Density
- ☐ Blood/Urine
- ☐ MRI
- ☐ Other_____

19) Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following:

- ☐ Cancer
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Mental Disorder
- ☐ Blood Pressure
- ☐ Arthritis
- ☐ Kidney Disease
- ☐ Stroke

20) Living Situation: (check all that apply)

- ☐ Alone
- ☐ With spouse/family member
- ☐ Living w/Caregiver
- ☐ In house/apartment
- ☐ Retirement Complex
- ☐ In Assisted living complex
- ☐ With stairs/rail
- ☐ With stairs/no rail
- ☐ Without stairs
- ☐ With ramp
- ☐ With elevator
- ☐ With uneven ground

21) When is the pain BETTER or decreased?

- ☐ Lying Down
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Heat
- ☐ Cold
- ☐ Exercises
- ☐ Sleeping/Night
- ☐ Pain pills
- ☐ Manipulation
- ☐ Injections for pain
- ☐ Muscle relaxant pills
- ☐ Massage
- ☐ Mornings
- ☐ End of day
- ☐ Movement
- ☐ Aspirin/anti-inflammatory pills
- ☐ Other:
- ☐ Absolutely nothing changes the pain

22) When is the pain WORSE or increased?

- ☐ Lying Down
- ☐ Sitting
- ☐ Walking
- ☐ Standing
- ☐ Massage
- ☐ Manipulation
- ☐ Exercise
- ☐ Mornings
- ☐ Cold
- ☐ Sleeping/Night
- ☐ Heat
- ☐ Stairs
- ☐ End of Day
- ☐ Movement
- ☐ Nothing makes it worse
- ☐ Cough/sneeze/deep breath
- ☐ Other:_____

23) Pain description (check all that apply)

- ☐ Sharp
- ☐ Burning
- ☐ Cramping
- ☐ Dull
- ☐ Shooting
- ☐ Achy
- ☐ Throbbing
- ☐ Other
- ☐ Periodic
- ☐ Occasional

24) Have you experienced dizziness? ◯ No ◯ Yes

25) Have you experienced numbness? ◯ No ◯ Yes

26) Please check all the following conditions that apply to you either presently or in the past:

- ☐ High Blood Pressure
- ☐ Blood Disorders
- ☐ Heart Surgery
- ☐ Epilepsy/Seizures
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Multiple Sclerosis
- ☐ Asthema
- ☐ Osteoporosis
- ☐ Emphysema/ Bronchitis
- ☐ Hearing Loss
- ☐ Gout
- ☐ Varicose Veins
- ☐ Hepatitis
- ☐ Dizziness/Fainting
- ☐ Arthritis
- ☐ Chemical Dependent
- ☐ Depression
- ☐ Tuberculosis
- ☐ Lung Disease
- ☐ Diabetes
- ☐ Cancer
- ☐ Emotional/Psychological Problems
- ☐ Other:

27) Please mark your Functional Level PRIOR to injury: Self-Care

- ☐ Independent in all self-care activities
- ☐ Difficulty performing self-care activities
- ☐ Difficulty performing household chores
- ☐ Need assistance with activities in community/outside of home

How did you hear about Dynamic Bracing & Physical Therapy, Inc.?

Occupational

- ☐ Employed full time
- ☐ Employed part time
- ☐ Full time student
- ☐ Homemaker
- ☐ Retired
- ☐ Self Employed
- ☐ Unemployed

28) Employment activities include:

- ☐ Sitting
- ☐ Standing
- ☐ Phone Use
- ☐ Repetitive Lifting
- ☐ Heavy Lifting
- ☐ Computer Use
- ☐ Heavy Equipment Operation
- ☐ Driving

29) Participation in Sports/Recreational Activities

- ☐ 5x or more/week
- ☐ 3/4x/week
- ☐ Stretching
- ☐ 1-2x/week
- ☐ Occasional
- ☐ Nordic Track
- ☐ Not Regularly
- ☐ None
- ☐ Aerobics
- ☐ Walking
- ☐ Running
- ☐ Jazzercise
- ☐ Swimming
- ☐ Biking
- ☐ Yoga
- ☐ Strengthening Exercises
- ☐ Weight Lifting
- ☐ Stationary Bike
- ☐ Other:

30) Have you fallen in the past year? ◯ No ◯ Yes

31) Are you aware of your current diagnosis? ◯ No ◯ Yes

32) Rate your average discomfort on the scale below

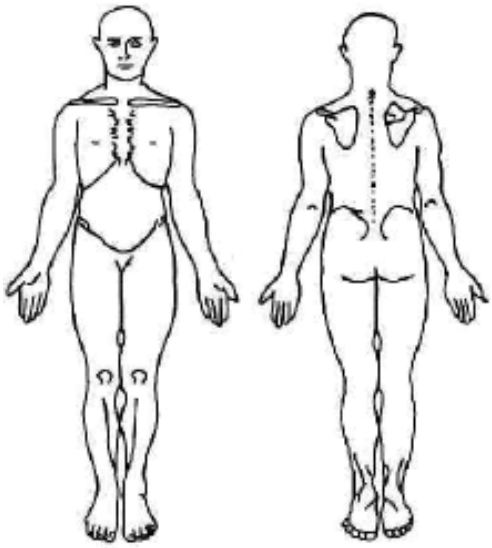
(_____)

0 **10**

Least **Most**

PLEASE MARK ON THE BODY CHART YOUR AREAS OF PAIN USING THE FOLLOWING SYMBOLS:

XXX = Pain 000 = Numbness and Tingling * = Weakness**



Patient Signature: _____

Patient Name: **Date:**