



Tel: 1-847-391-9720 • 9301 W. Golf Road, Suite 204 • Des Plaines, IL 60016 • Fax: 1-847-391-9721

Name: \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

MEDICAL HISTORY QUESTIONNAIRE

- Are you working now?..... Yes / No
Do you have a cardiac problem?..... Yes / No
Do you have a cardiac pacemaker?..... Yes / No
Do you have a metal implant?..... Yes / No
Do you have any joint replacements?..... Yes / No
Do you have a history of cancer?..... Yes / No
Do you have high blood pressure?..... Yes / No
Do you have a history of high cholesterol?..... Yes / No
Do you have diabetes?..... Yes / No
Do you have a history of seizures?..... Yes / No
Do you smoke?..... Yes / No
Any recent X-rays/MRI/CT?..... Yes / No

If yes, when? \_\_\_\_\_

- FEMALES: Are you pregnant?..... Yes / No
Have you ever had Physical Therapy, Occupational Therapy or Speech Therapy before?..... Yes / No
If yes, please describe: \_\_\_\_\_

Present Medications: \_\_\_\_\_

Allergies / Reactions: \_\_\_\_\_

Pertinent Medical History / Surgeries: \_\_\_\_\_

What is your major complaint? \_\_\_\_\_

How and when did it start? \_\_\_\_\_

Have you ever had anything similar before?..... Yes / No

Do you have any pain?..... Yes / No

If yes, is your pain a: Throb Twinge Burning Other \_\_\_\_\_

Where is the pain located? \_\_\_\_\_

What makes your pain worse? (ie sitting, standing, etc.): \_\_\_\_\_

What eases your pain? \_\_\_\_\_

Rate your pain at this time: 0 1 2 3 4 5 6 7 8 9 10 (0-1 mild

The best it has been since injury: 0 1 2 3 4 5 6 7 8 9 10 9-10 severe)

The worst it has ever been: 0 1 2 3 4 5 6 7 8 9 10

What are you unable to do because of your pain/problem? \_\_\_\_\_