Weiss Physical Therapy & Rehabilitation

www.WeissPTrehab.com

55 Schanck Road
Suite A-2
Freehold, NJ 07728
P: 732-303-1575
F: 732-303-5905

MEDICAL HISTORY / Health Questionnaire

Name: ______________________________ **Date:** ________________

Family Physician: ____________________ **Referring Physician:** ________________

Date of 1st doctor visit for this injury: __________

Last Day worked due to this injury**:** __________ Date returned to work after this injury: ________

Is an attorney involved in this case? YES NO

Have you had surgery for this injury? YES NO Number of surgeries? __________

Type of surgery? ____________________ Took place in: Hospital or OP Surgi-center

Are you currently taking? Anti-inflammatories Muscle Relaxers Pain Medication

Please list above medications: ______________________________

Please list allergies: ______________________________

Have you ever had any of the following services for this injury? Please circle all that apply.

General Practitioner	Orthopedist	Neurologist	Rheumatologist
Podiatrist	Chiropractor	Physical Therapy	Occupational Therapy
Massage Therapy	Emergency Hospital Care		

X-Rays MRI CT scan EMG/NCV Myelogram

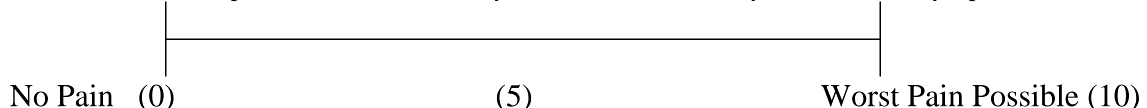
Results: ______________________________

On the diagram below, please indicate where your current symptoms are located.

KEY:

Numbness	= = = = = = =
Pins & Needles	/ / / / / / / / /
Burning Pain	x x x x x x x
Aching Pain	o o o o o o o

On the line below, please indicate how you would describe your current symptoms.



No Pain (0) (5) Worst Pain Possible (10)

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Please read and answer the following question. Do you now or have you ever had any of the following?

	YES	NO	Diagnosing MD
Arthritis	☐	☐	____________
Osteopenia/Osteoporosis	☐	☐	____________
Bursitis or tendinitis	☐	☐	____________
Bone or Joint problems	☐	☐	____________
Joint replacement or Implant	☐	☐	____________
Low Back Pain	☐	☐	____________
Neck pain	☐	☐	____________
Multiple Sclerosis	☐	☐	____________
Parkinson's disease	☐	☐	____________
Lyme's Disease	☐	☐	____________
Seizure Disorder	☐	☐	____________
Diabetes (I or II)	☐	☐	____________
High Blood Pressure	☐	☐	____________
Low Blood Pressure	☐	☐	____________
Angina	☐	☐	____________
Heart Disease	☐	☐	____________
Coronary artery disease	☐	☐	____________
Do you have a pacemaker?	☐	☐	____________

	YES	NO	Diagnosing MD
Congestive Heart Failure	☐	☐	____________
Stroke	☐	☐	____________
Cancer or Tumors	☐	☐	____________
Aneurysms	☐	☐	____________
Anemia	☐	☐	____________
Peripheral Vascular Disease	☐	☐	____________
Persistent Swelling	☐	☐	____________
Shortness of Breath	☐	☐	____________
Episodes of dizziness/fainting	☐	☐	____________
Frequent Headaches	☐	☐	____________
Asthma	☐	☐	____________
Bronchitis	☐	☐	____________
Emphysema	☐	☐	____________
Ulcers	☐	☐	____________
Emotional/Psych disorder	☐	☐	____________
Bowel/Bladder difficulty	☐	☐	____________
Hernia	☐	☐	____________
Visual / Hearing Impairment	☐	☐	____________
Do you smoke?	☐	☐	____________
Are you pregnant?	☐	☐	____________

Please list any medications you are currently taking:

____

____

Please list and date any prior hospitalizations or surgeries:

____

____

Please let us know what your personal goals are with therapy:

____

____

Patient's name: (Please print) ____ **Date:** ____________

Signature: ____ **PT Init:** __________