UPPER PERK PHYSICAL THERAPY & SPORTS REHAB., INC./
NEW HOPE PHYSICAL THERAPY & SPORTS REHAB.
MEDICAL QUESTIONNAIRE

Name_______________________________________ Referring Physician____________________________
Family Physician & phone number: ____
Date of Dr. Visit for this injury: _________________ Last date worked due this injury: ________________
Is an attorney involved: YES or NO Have you had surgery for this injury: YES or NO
If yes, date of surgery: _______________________ Type of surgery: ________________________________
Please list all medications: ____
____
Please list all allergies: ____

PRESENT PAIN SCALE FOR INJURY/SURGERY (OUR OF 10 – 10 BEING YOUR WORSE PAIN): _____________

Have you had any of the following medical services for this injury/surgery? (check YES or NO)

	YES	NO		YES	NO
Speech Therapy	_____	_____	Home health care	_____	_____
Chiropractor	_____	_____	CT Scan	_____	_____
EMG/NCV	_____	_____	General Practioner	_____	_____
Massage Therapy	_____	_____	MRI	_____	_____
Myelogram	_____	_____	Neuologist	_____	_____
Occupational Therapy	_____	_____	Orthopedist	_____	_____
Emergency Room Care	_____	_____	X-rays	_____	_____
Hospital Stay	_____	_____	Skilled Nursing Facility Stay	_____	_____

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO
Asthma/Bronchitis/Emphysema	_____	_____	Severe or Frequent Headaches	_____	_____
Shortness of breath/Chest pain	_____	_____	Vision or hearing	_____	_____
Coronary heart disease or Angina	_____	_____	Numbness or Tingling	_____	_____
Do you have a pacemaker?	_____	_____	Dizziness of Fainting	_____	_____
High Blood pressure	_____	_____	Bowel or bladder problems	_____	_____
Heart attack or heart surgery	_____	_____	Weakness	_____	_____
Stroke/TIA	_____	_____	Weight loss/Energy loss	_____	_____
Congestive heart failure	_____	_____	Hernia	_____	_____
Blood clot/Emboli/DVT	_____	_____	Varicose Veins	_____	_____
Epilepsy/Seizures	_____	_____	Allergies	_____	_____
Thyroid disease or Goiter	_____	_____	Metal implants or pins	_____	_____
Anemia	_____	_____	Joint replacement surgery	_____	_____
Infectious disease	_____	_____	Neck injury/surgery	_____	_____
Diabetes	_____	_____	Shoulder injury/surgery	_____	_____
Cancer or Chemo/Radiation	_____	_____	Elbow/Hand surgery	_____	_____
Osteoporosis	_____	_____	Knee injury/surgery	_____	_____
Gout	_____	_____	Leg/Ankle/Foot injury/surgery	_____	_____
Sleeping difficulties	_____	_____	Are you pregnant	_____	_____
Emotional/Psychological problems	_____	_____	Do you use tobacco?	_____	_____

Is there any additional information that would assist us with your care? _________________________________
____

What are your rehabilitation expectations/goals while in this program? __________________________________
____

Patient/Guardian Signature: ____ Date: ___________________________