Burkhardt
Physical Therapy Center, LLC

Patient Questionnaire / Medical History Form

This information is protected under HIPAA laws. Please answer all questions to the best of your ability.

Name: _____ **Date:** _____

Occupation: _____ **Current Work Status:** _____

Do you have any lifting restrictions? ☐ N ☐ Y: _____

What is the reason for your visit today? _____

If accident, check place where occurred: ☐ Home ☐ Auto ☐ Work ☐ Sports ☐ Other: _____

Briefly describe how your problem began: _____

What goals would you like to achieve through therapy? _____

Date of onset/injury: _____ **Date of surgery:** _____ **Type of Surgery:** _____

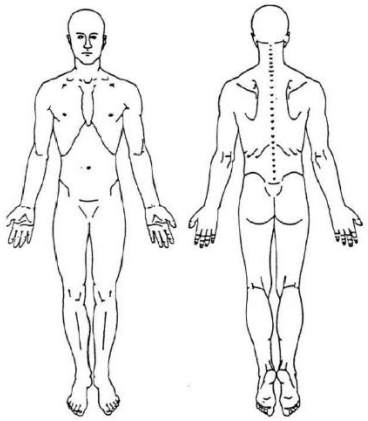
Have any diagnostic tests been performed for this problem? (check all that apply)

☐ X-rays ☐ Bone Scan ☐ Ultrasound ☐ MRI ☐ EMG ☐ CT Scan ☐ Blood Work ☐ Other: _____

Please list body part tested and date tested: _____

Have you received any other physical therapy (including home health PT) prior to coming here? ☐ Y ☐ N

Please circle where you hurt:



Since the pain started, the pain is: ☐ getting worse ☐ improving ☐ the same

Describe pain: ☐ sharp ☐ dull ☐ aching ☐ sore ☐ throbbing ☐ cramping ☐ burning ☐ shooting ☐ stabbing ☐ squeezing ☐ constant ☐ intermittent ☐ other: _____

What makes it worse? _____

What makes it better? _____

Does time of day affect pain? _____

Does pain wake you from sleep? _____

Please rate your pain on a scale of 0-10 with 0 being no pain and 10 being the worst pain you can imagine:

Best: 0 1 2 3 4 5 6 7 8 9 10 **Worst:** 0 1 2 3 4 5 6 7 8 9 10 **Present:** 0 1 2 3 4 5 6 7 8 9 10

Do you have tingling, numbness, or loss of sensation? ☐ Y ☐ N If so, where? _____

Do you have weakness? ☐ Y ☐ N If yes, for how long? _____

Do you have swelling? ☐ Y ☐ N If yes, where? _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Give answers as 0 to 3, using this scale:

0=Not at all 1=Several days 2=More than half the days 3=Nearly every day

1. Little interest or pleasure in doing things ☐ 0 ☐ 1 ☐ 2 ☐ 3

2. Feeling down, depressed, or hopeless ☐ 0 ☐ 1 ☐ 2 ☐ 3

Have you had any falls in the past year? ☐ Y ☐ N If so, how many? _____

How would you rate your overall Health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Please choose Y (yes) or N (no) if you have had any of the following conditions:

High Blood Pressure	☐ Y ☐ N	High Cholesterol	☐ Y ☐ N	Bowel/Bladder Problem	☐ Y ☐ N
Fibromyalgia	☐ Y ☐ N	Kidney Disease	☐ Y ☐ N	Bleeding Disorder/Clot	☐ Y ☐ N
HIV/AIDS	☐ Y ☐ N	Seizures/Epilepsy	☐ Y ☐ N	Lyme Disease	☐ Y ☐ N
Currently Pregnant	☐ Y ☐ N	Diabetes	☐ Y ☐ N	Stroke	☐ Y ☐ N
# of weeks: _____		Type: _____		Year(s): _____	
Heart Attack	☐ Y ☐ N	Hepatitis	☐ Y ☐ N	Osteoarthritis	☐ Y ☐ N
Autoimmune Disease	☐ Y ☐ N	Thyroid Disease	☐ Y ☐ N	Cancer	☐ Y ☐ N
Type: _____		Type: _____		Type: _____	
Dizziness/Fainting	☐ Y ☐ N	Osteoporosis/penia	☐ Y ☐ N	Scoliosis	☐ Y ☐ N
Headaches/Migraines	☐ Y ☐ N	Dementia/Alzheimer's	☐ Y ☐ N	Recent Infection	☐ Y ☐ N
Implanted Device	☐ Y ☐ N	Chronic Fatigue	☐ Y ☐ N	Anxiety	☐ Y ☐ N
Depression	☐ Y ☐ N	Vertigo	☐ Y ☐ N	DNR	☐ Y ☐ N

Allergies ☐ Y ☐ N

Please list: _____

Please list previous surgeries with dates. Also include any disorders not listed above:

_____

_____

To the best of my ability, I have given and included all pertinent information:

Patient/Guardian Signature: _____ Date: _____

Returning Patient: I have reviewed my medical history and updated it as needed. Initials: _____

Medical history reviewed by physical therapist and used in determining the plan of care.

Therapist Signature: _____ Date: _____