

Medical History Questionnaire

Name: _____

Referring Physician _____

Family Physician _____

Reason you are here today: _____

Have you had surgery due to this injury Yes No

Number of Surgeries _____

Type of Surgery _____

EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP _____

Are you currently taking any prescription or non-prescription medications? Yes No

If yes, please list them _____

** If you need more space, please continue listing on back of this page.**

Have you had any of the following Medical or Rehabilitative Services for this Injury/Episode?

<table border="0"> <tr><td>Chiropractor</td><td style="text-align: center;">YES</td><td><input type="checkbox"/></td></tr> <tr><td>EMG/NCV</td><td style="text-align: center;">YES</td><td><input type="checkbox"/></td></tr> <tr><td>Massage Therapy</td><td style="text-align: center;">YES</td><td><input type="checkbox"/></td></tr> <tr><td>Myelogram</td><td style="text-align: center;">YES</td><td><input type="checkbox"/></td></tr> <tr><td>Occupational Therapy</td><td style="text-align: center;">YES</td><td><input type="checkbox"/></td></tr> <tr><td>Physical Therapy</td><td style="text-align: center;">YES</td><td><input type="checkbox"/></td></tr> <tr><td>Emergency Room Care</td><td style="text-align: center;">YES</td><td><input type="checkbox"/></td></tr> </table>	Chiropractor	YES	<input type="checkbox"/>	EMG/NCV	YES	<input type="checkbox"/>	Massage Therapy	YES	<input type="checkbox"/>	Myelogram	YES	<input type="checkbox"/>	Occupational Therapy	YES	<input type="checkbox"/>	Physical Therapy	YES	<input type="checkbox"/>	Emergency Room Care	YES	<input type="checkbox"/>	<table border="0"> <tr><td>CT Scan</td><td style="text-align: center;">YES</td><td><input type="checkbox"/></td></tr> <tr><td>General Practitioner</td><td style="text-align: center;">YES</td><td><input type="checkbox"/></td></tr> <tr><td>MRI</td><td style="text-align: center;">YES</td><td><input type="checkbox"/></td></tr> <tr><td>Neurologist</td><td style="text-align: center;">YES</td><td><input type="checkbox"/></td></tr> <tr><td>Orthopedist</td><td style="text-align: center;">YES</td><td><input type="checkbox"/></td></tr> <tr><td>Podiatrist</td><td style="text-align: center;">YES</td><td><input type="checkbox"/></td></tr> <tr><td>X-Rays</td><td style="text-align: center;">YES</td><td><input type="checkbox"/></td></tr> </table>	CT Scan	YES	<input type="checkbox"/>	General Practitioner	YES	<input type="checkbox"/>	MRI	YES	<input type="checkbox"/>	Neurologist	YES	<input type="checkbox"/>	Orthopedist	YES	<input type="checkbox"/>	Podiatrist	YES	<input type="checkbox"/>	X-Rays	YES	<input type="checkbox"/>
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Do you now have or have you ever had ANY of the following?

<p>Lungs:</p> <p style="text-align: center;">YES</p> <p>Asthma <input type="checkbox"/></p> <p>Bronchitis <input type="checkbox"/></p> <p>Emphysema <input type="checkbox"/></p> <p>Tuberculosis <input type="checkbox"/></p> <p>Orthopedic:</p> <p style="text-align: center;">YES</p> <p>Arthritis/Swollen Joints <input type="checkbox"/></p> <p>Osteoporosis <input type="checkbox"/></p> <p>Gout <input type="checkbox"/></p> <p>Any Pins or Metal Implants <input type="checkbox"/></p> <p>Neck Injury/Surgery <input type="checkbox"/></p> <p>Shoulder Injury/Surgery <input type="checkbox"/></p> <p>Elbow/Hand Injury Surgery <input type="checkbox"/></p> <p>Weakness <input type="checkbox"/></p> <p>Leg/Ankle/Foot Injury/Surgery <input type="checkbox"/></p> <p>Knee Injury/Surgery <input type="checkbox"/></p> <p>Back Injury/Surgery <input type="checkbox"/></p> <p>Hernia <input type="checkbox"/></p> <p>Other _____ <input type="checkbox"/></p>	<p>Cardiovascular:</p> <p style="text-align: center;">YES</p> <p>High Blood Pressure <input type="checkbox"/></p> <p>Shortness of Breath/ Chest Pain <input type="checkbox"/></p> <p>Heart Attack or Surgery <input type="checkbox"/></p> <p>Stroke/TIA <input type="checkbox"/></p> <p>Coronary Heart Disease or Angina <input type="checkbox"/></p> <p>Blood Clot/emboli <input type="checkbox"/></p> <p>Anemia <input type="checkbox"/></p> <p>Do you have a pacemaker? <input type="checkbox"/></p> <p>Other Systemic:</p> <p style="text-align: center;">YES</p> <p>Diabetes <input type="checkbox"/></p> <p>Infectious Diseases <input type="checkbox"/></p> <p>Thyroid Trouble/ Goiter <input type="checkbox"/></p> <p>Cancer or Chemotherapy/Radiation <input type="checkbox"/></p> <p>Allergies <input type="checkbox"/></p> <p>Bowel or Bladder Problems <input type="checkbox"/></p> <p>Epilepsy/Seizures <input type="checkbox"/></p> <p>Severe or Frequent Headaches <input type="checkbox"/></p> <p>Vision or Hearing Difficulties <input type="checkbox"/></p> <p>Numbness or Tingling <input type="checkbox"/></p> <p>Dizziness or Fainting <input type="checkbox"/></p> <p>Ringing in Your Ears <input type="checkbox"/></p>	
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Please answer the following questions:

Do you Smoke?	YES	NO	QUIT (How long ago? _____)
Do you have Sleeping Problems or Difficulties?	YES	NO	
Do you have any Emotional or Psychological Problems?	YES	NO	
(Women): Are you Pregnant?	YES	NO	IF yes; what is your Due Date? _____
Have you ever had to take any steroid medications?	YES	NO	
Have you ever had to take any blood thinning medications?	YES	NO	
Do you understand your diagnosis?	YES	NO	

Please list any other information that you feel would assist us in your care: _____

How did you hear about ISMPT of Loudoun, LLC? _____

Patient Signature: _____ Date: _____

Reviewed with Patient: _____ Date: _____

(Evaluating Therapist's Initials)