ADVANCED PHYSICAL THERAPY & ERGONOMICS, INC.

Patient Medical History and Symptom Questionnaire

1. General Medical Conditions:

Allergies	Y	N	Dizzy Spells	Y	N	MRSA	Y	N
Anemia	Y	N	Emphysema/Bronchitis	Y	N	Multiple Sclerosis	Y	N
Anxiety	Y	N	Fibromyalgia	Y	N	Muscular Disease	Y	N
Arthritis	Y	N	Fractures	Y	N	Osteoporosis	Y	N
Asthma	Y	N	Gallbladder Problems	Y	N	Parkinsons	Y	N
Autoimmune Disorder	Y	N	Headaches	Y	N	Rheumatoid Arthritis	Y	N
Cancer	Y	N	Hearing Impairment	Y	N	Seizures	Y	N
Cardiac Conditions	Y	N	Hepatitis	Y	N	Smoking	Y	N
Cardiac Pacemaker	Y	N	High Cholesterol	Y	N	Speech Problems	Y	N
Chemical Dependency	Y	N	High/Low Blood Pressure	Y	N	Strokes	Y	N
Currently Pregnant	Y	N	HIV/AIDS	Y	N	Thyroid Disease	Y	N
Circulation Problems	Y	N	Incontinence	Y	N	Tuberculosis	Y	N
Depression	Y	N	Kidney Problems	Y	N	Vision Problems	Y	N
Diabetes	Y	N	Metal Implants	Y	N			

Please explain any yes answer & give approximate dates: _____

_____

Please describe any other illnesses/conditions: _____

_____

Prior surgery(s): _____

Falls in the last year: _____

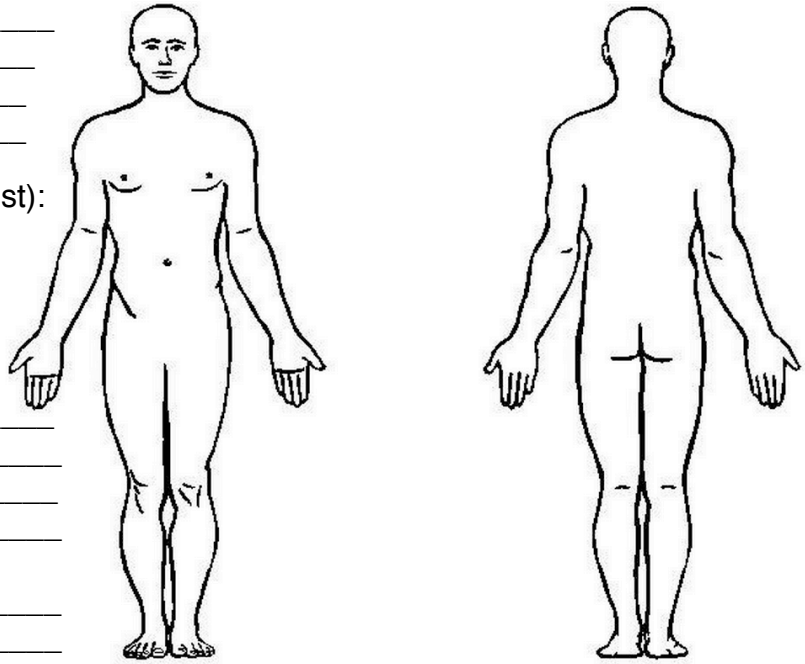
2. **Please indicate on the diagram where your symptoms are located and the type of symptoms you are having (sharp pain, dull pain, numbness, tingling, tightness, burning, etc.)**

When did your problem start: _____

How did your problem start: _____

_____

_____



Please rate the following 0-10 (0=lowest & 10=highest):

Current level of pain _____

Lowest amount of pain in last 2 weeks _____

Highest amount of pain in last 2 weeks _____

What makes your problem better: _____

_____

What makes your problem worse: _____

_____

What are your main recreational activities: _____

_____

What are your main limitations: _____

_____

What are your main goals: _____

_____

(please list any medications on the reverse)

Please List any Medications you are Currently Taking

Medication	Dosage	Frequency	Reason Taking

Please use the space below to tell us about anything else that you think we should know:

_____

_____

_____

_____

_____

_____

Name: _____ Signature: _____ Date: _____