Medical History Questionnaire

Date of Evaluation:

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and your therapist will assist you. Thank you!

Last Name | MI : | DOB: | Age: | Sex: | Merital Status:

First Name | Weight (lb): | Height (in): | BMI lb/in2:

Address

City | State | Zip Code

Ph: | Ex:

Occupation:

Please check any of the followings whose care you are under:

- ☐ Medical Doctor
- ☐ Psychologist/Psychiatrist
- ☐ Dentist
- ☐ Osteopath
- ☐ Physical Therapist
- ☐ Other
- ☐ Chiropractor

Date of last physical exam:

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.):

Please describe THE Reason which brought you here (Pain/symptoms, how and when):

Leisure Act.:

Have you or your blood relatives EVER been diagnosed as having any of the following conditions?

Self Yes	Self No	Family Yes	Family No		Self Yes	Self No	Family Yes	Family No	
☐	☐	☐	☐	Cancer If YES, what kind	☐	☐	☐	☐	Kidney Problem If YES, what kind
☐	☐	☐	☐	Heart Problems If YES, what kind	☐	☐	☐	☐	Rheumatoid Arthritis
☐	☐	☐	☐	High Blood Pressure	☐	☐	☐	☐	Other arthritic conditions
☐	☐	☐	☐	Circulation Problems	☐	☐	☐	☐	Depression
☐	☐	☐	☐	Ashthma	☐	☐	☐	☐	Hepatitis
☐	☐	☐	☐	Stomach Ulcers	☐	☐	☐	☐	Tuberculosis
☐	☐	☐	☐	Chemical Dependency (such as alcohol)	☐	☐	☐	☐	Stroke
☐	☐	☐	☐	Thyroid Problems	☐	☐	☐	☐	Blood clots
☐	☐	☐	☐	Diabetes	☐	☐	☐	☐	Osteoporosis
☐	☐	☐	☐	Multiple Sclerosis	☐	☐	☐	☐	Rheumatic Fever
☐	☐	☐	☐	Bronchitis	☐	☐	☐	☐	Other If YES, what kind

During the past month have you been feeling down, depressed or hopeless? ☐ Yes ☐ No

During the past month have you been bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ☐ Yes ☐ No

In the past three months, have you had or did you experience:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Chest Pain	☐	☐	Numbness/tingling	☐	☐	Urinary Tract Infection	☐	☐	Changes in bowel functio
☐	☐	Head Ache	☐	☐	Difficulty Swallowing	☐	☐	Nausea/vomitting	☐	☐	Changes in bladder functi
☐	☐	Seizure	☐	☐	Shortness of breath	☐	☐	Unexplained wt change	☐	☐	Upper respiratory infectio
☐	☐	Fever/chills/sweats	☐	☐	Dizziness	☐	☐	Changes in appetite			

Please list surgeries or other conditions for which you have been hospitalized, include the approximate date and reason for the surgery or hospitalization:

Date	Reason (Procedure/hospitalization)	Date	Reason (Procedure/hospitalization)

Are you latex sensitive? ☐ Yes ☐ No List any other allergies we should know about

List any medication you are allergic to:

Have you declared the Advanced Clinical Directive of Do Not Resuscitate? ☐ ☐

Medications:

Tests (XRays, MRI, Bone scane) and dates:

Are you pregnant? ☐ Yes ☐ No

How are you sleeping at night?

- ☐ Fine
- ☐ Moderate Difficulty
- ☐ Only with medications

I currently have difficulty with

- ☐ Driving
- ☐ Getting up from chair
- ☐ Walking
- ☐ Other

With time, are your symptoms

- ☐ Getting worse
- ☐ The same
- ☐ Getting better
- ☐ Other

Tobacco use: # of packs/day years: Date quit: Second hand smoke? ☐ Yes ☐ No

Alcohol use: Qty. (Oz.)/day years: Date quit: Alcoholism in family? ☐ Yes ☐ No

Caffeine: Qty. (Oz.)/day years: Date quit:

Falls: # of falls/year Date last fall: Reason:

- ☐ Dizziness
- ☐ Blackout
- ☐ Spinning
- ☐ Other

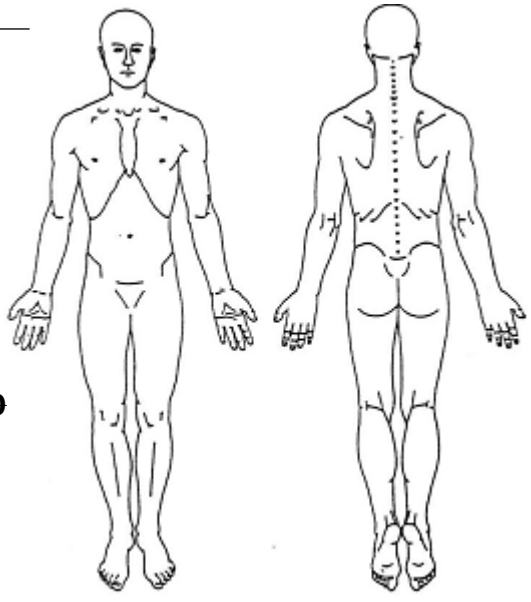
Pain:

- ☐ Sharp
- ☐ Ache
- ☐ Shooting
- ☐ Tingling
- ☐ Burning
- ☐ Numb
- ☐ Dull
- ☐ Heavy
- ☐ Throbbing
- ☐ Tight
- ☐ Pulling
- ☐ Stabbing

Pain behavior:

- ☐ Constant (never goes away)
- ☐ Intermittent (relieved with position)
- ☐ Occasionally (Daily or less frequently)
- ☐ Infrequent (Once in a week)
- ☐ Variable (come and goes)

Please mark the areas of your symptoms:



Please mark the severity of your pain on the line below:

0 1 2 3 4 5 6 7 8 9 10

Goals/ Expectations:

Comments:

The above statements are true to the best of my knowledge

Patient's Name & Signature: Date :

Therapist's Name & Signature: Date :

Print Form

Submit by Email

Revive Rehab Services, LLC | Allentown, PA 18104 | Ph: (w) (484) 891-0608, (c) (610) 570-4307 | Fax: (484) 866-8876 | Email: info.reviverehab@gmail.com
www.reviverehabservices.com