

# SET SPORTS PHYSICAL THERAPY

## Patient Health and Medical History Questionnaire

Patient's Name \_\_\_\_\_

Have you recently been hospitalized?  Yes  No

If yes, please specify: \_\_\_\_\_

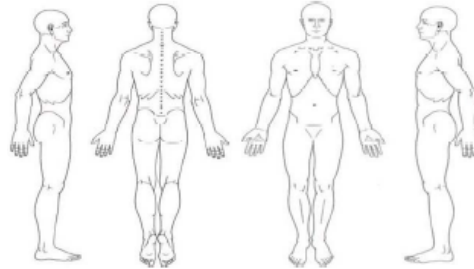
Are you currently taking any medications (including over-the-counter)?  Yes  No

If yes, please list: \_\_\_\_\_

Describe the nature of your symptoms (check all that apply):

- Sharp/shooting
- Dull/aching
- Deep/Throbbing

Indicate the location of you pain and/or symptoms



Describe your current symptoms:  
When did your symptoms start? \_\_\_\_\_

How did your symptoms begin? \_\_\_\_\_

During the past 2 weeks, describe how this condition has affected your work (including housework): \_\_\_\_\_

Who have you seen regarding this condition?

- Medical Doctor  Osteopath  Chiropractor  Acupuncturist  Physical Therapist  Other

Have you had any of the following tests for this condition?

- Xray, date \_\_\_\_\_  MRI, date \_\_\_\_\_  CT Scan, date \_\_\_\_\_  Other, date \_\_\_\_\_

Have you had similar symptoms in the past?  Yes  No

If yes, please specify: \_\_\_\_\_

### Medical History

Have you been diagnosed with any of the following:

	YES	NO
Cancer/type .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems .....	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension .....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Dx .....	<input type="checkbox"/>	<input type="checkbox"/>
Osetoarthritis .....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis .....	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify) \_\_\_\_\_

- Do you have bowel/bladder problems? .....  YES  NO
- Do you have numbness/tingling in both hands or both feet? .....  YES  NO
- Do you have dizziness, nausea, or vomiting? .....  YES  NO
- Do you experience blurred vision? .....  YES  NO
- Do your symptoms increase with emotional stress or exertion? .....  YES  NO
- Do you have increased pain with coughing or sneezing? .....  YES  NO

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_