Visions At Home Physical Therapy
105 Northgate Rd., Suite E • Natchez, MS 39120
Phone: 601 - 568 – 1313 • Fax: 601 – 653 – 9261
Website: visionsathomept.com

Medical History Questionnaire

Name: _____ **DOB**: _____ **Age**:_____ **Ht**:_____ **Wt**:_____

Why are you seeking therapy?_____

_____

Describe your injury - How and when it started: _____

_____

Is there any legal action related to injury: ☐ Yes ☐ No

Employment: ☐ Full Time ☐ Part Time ☐ Student ☐ Retired ☐ Disabled ☐ Other _____
Occupation: _____ Employer: _____ Length of employment: _____
Are you currently working: ☐ Yes ☐ No

Home Status / Functional Level

Lives (with) ☐ Alone ☐ Spouse/Partner ☐ Family_____ ☐ Friends ☐ Other
Home ☐ 1-story with / without basement ☐ 2-story home with / without basement
☐ Apartment with / without elevator ☐ Mobile home ☐ Other _____
Maximum # of stairs to walk at any one time in home _____ Are there handrails? ☐ Yes ☐ No

Health History:

Currently receiving any home health services: ☐ Yes ☐ No
Previous therapy for this injury or ailment: ☐ Yes ☐ No If yes, how many visits? ____ When?_____
Number of falls in the last month? _____ **In the last year?** _____
Do You? ☐ Smoke *How much?* _____ ☐ Drink alcohol *How much?* _____ ☐ Caffeine? *How much?* _____

Check each condition that relates to you:

☐ Pacemaker / Defibrillator
☐ Osteoporosis, Osteopenia
☐ Arthritis (osteo, rheumatoid)
☐ Bleeding tendencies
☐ Cancer (_____)
☐ High Blood Pressure
☐ Diabetes (type _____)
☐ Frequent Nausea/Vomiting
☐ Heart Disease / Attack
☐ Stomach Disorders
☐ Liver Disorder
☐ Kidney Disease
☐ Bowel / Bladder issue
☐ Thyroid disease
☐ Allergies: _____
☐ Tape / Latex Allergy
☐ Skin Disease
☐ HIV (+)
☐ Mental Health Issues
☐ Lung Disease / Asthma
☐ Seizure Disorder
☐ Unexplained weight gain/loss
☐ Circulation Problems
☐ Blood Clots
☐ Metal Implants _____
☐ Stroke
☐ Pregnant # of months___
☐ Neurological Disorder
☐ Other: _____

Adaptive / Assistive Equipment Owned

☐ None ☐ Crutches ☐ Wheeled Walker ☐ Transfer tub bench ☐ Bedside commode ☐ Hospital Bed
☐ Cane ☐ Walker ☐ Wheelchair ☐ Grab bars ☐ Lift chair ☐ _____

List any surgeries that may be associated with your condition (include date):

_____

List all current medications including over-the-counter types *(If you have a list, we will photocopy it)*

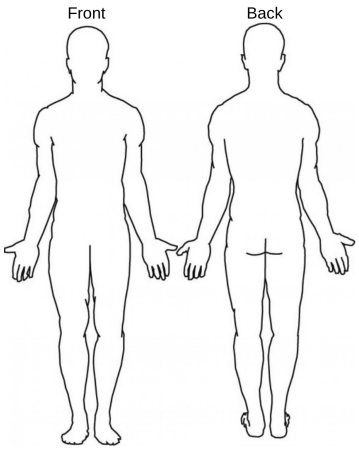
_____

_____

How frequently are you using pain medications for this condition?

☐ Every 3-4 hours ☐ Daily ☐ Weekly ☐ Intermittently / as needed ☐ Do not use

What are you using for pain medications? _____



Rate your pain on a scale of 0-10 (0=no pain, 10=worst pain)
Current _____ at best _____ at worst _____

Please mark symptoms on the body diagram
X = area of pain **O =** area of numbness / tingling

Are your symptoms getting? (check one) ☐ Better ☐ Worse

Are your symptoms generally? (check box and circle word)
☐ Better / worse in morning ☐ Better / worse in afternoon
☐ Better / worse while sleeping ☐ Better then worsens as day goes on

Pain Behavior: ☐ Constant ☐ Intermittent ☐ Dull ☐ Achy ☐ Sharp
☐ Burning ☐ Stabbing ☐ Throbbing ☐ Radiating ☐ _____

Have you had any of the following for this condition? (If yes, state results)

☐ None
☐ X-ray _____
☐ MRI _____
☐ CT Scan _____
☐ Bone Scan _____
☐ Arthrogram _____
☐ EMG _____
☐ Diagnostic Arthroscopy
☐ Doppler / Ultrasound

Previous treatment(s) for this condition: Check all that apply. (Circle helpful treatments)

☐ None
☐ Medication_____
☐ P.T. / O.T.
☐ Chiropractic
☐ Massage Therapy
☐ Exercise
☐ Injections
☐ Acupuncture
☐ TENS Unit
☐ Traction
☐ Surgery
☐ Splinting / Taping
☐ Bracing
☐ Pain Clinic
☐ Other _____

Functional Limitations: Place a check next to each activity that causes you pain or difficulty.

☐ Sitting	☐ Lay on back / side / stomach	☐ Putting on socks / shoes	☐ Reaching to floor
☐ Standing	☐ Bathing tasks	☐ Going up / down stairs	☐ Lifting to waist level
☐ Walking	☐ Grooming tasks	☐ Open / close doors	☐ Reaching overhead
☐ Sleeping	☐ Dressing Tasks	☐ Carrying items while walking	☐ _____

What are your goals for therapy? _____

_____