# UPPER PERK PHYSICAL THERAPY & SPORTS REHAB

## MEDICAL QUESTIONNAIRE

Name: _____ Referring Physician: _____
Family Physician & Phone #: _____
Date of doctor visit for this injury: _____ Last date worked due to this injury: _____
Is an attorney involved: YES OR NO Have you had surgery for this injury: YES OR NO
If yes, date of surgery: _____ Type of surgery: _____
**PRESENT PAIN SCALE FOR INJURY/SURGERY (out of 10 – 10 being your worse pain):** _____

Have you had any of the following medical services for this injury/surgery? (check yes or no)

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Speech Therapy | ___ | ___ | Home Health Care | ___ | ___ |
| Chiropractor | ___ | ___ | CT Scan | ___ | ___ |
| EMG/NCV | ___ | ___ | General Practitioner | ___ | ___ |
| Massage Therapy | ___ | ___ | MRI | ___ | ___ |
| Myelogram | ___ | ___ | Neurologist | ___ | ___ |
| Occupational Therapy | ___ | ___ | Orthopedist | ___ | ___ |
| Physical Therapy | ___ | ___ | Podiatrist | ___ | ___ |
| Emergency Room Care | ___ | ___ | X-Rays | ___ | ___ |
| Hospital Stay | ___ | ___ | Skilled Nursing Facility stay | ___ | ___ |

**Do you now have or have you ever had any of the following?**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Asthma/Bronchitis/Emphysema/COPD | ___ | ___ | Severe or frequent headaches | ___ | ___ |
| Shortness of breath/Chest pain | ___ | ___ | Vision or hearing difficulties | ___ | ___ |
| Coronary heart disease or Angina | ___ | ___ | Numbness or Tingling | ___ | ___ |
| Do you have a pacemaker? | ___ | ___ | Dizziness or Fainting | ___ | ___ |
| High blood pressure | ___ | ___ | Bowel or bladder problems | ___ | ___ |
| Heart attack or heart surgery | ___ | ___ | Weakness | ___ | ___ |
| Stroke/TIA | ___ | ___ | Weight loss/Energy loss | ___ | ___ |
| Congestive heart failure | ___ | ___ | Hernia | ___ | ___ |
| Blood clot/Emboli/DVT | ___ | ___ | Varicose Veins | ___ | ___ |
| Epilepsy/Seizures | ___ | ___ | Allergies | ___ | ___ |
| Thyroid disease or Goiter | ___ | ___ | Metal implants or pins | ___ | ___ |
| Anemia | ___ | ___ | Joint replacement surgery | ___ | ___ |
| Infectious disease | ___ | ___ | | | |
| Diabetes | ___ | ___ | Anxiety/Depression | ___ | ___ |
| Cancer or Chemo/Radiation | ___ | ___ | Do you drink alcohol? | ___ | ___ |
| Arthritis | ___ | ___ | How many drinks per day? | _____ | |
| Osteopenia/Osteoporosis | ___ | ___ | Do you use tobacco? | ___ | ___ |
| Gout | ___ | ___ | Are you pregnant? | ___ | ___ |

Do you feel safe at home? _____
Have you been harmed in any way, physically or mentally, at home in the last year? _____.
Please list all surgeries/injuries: _____
_____.
Is there any additional information that would assist us with your care? _____
_____
What are your rehabilitation expectations/goals while in this program? _____
_____

**Patient/Guardian Signature**: _____ **Date:** _____

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**Patient Medication List**

| Medication | Dosage | Frequency | Route of Administration |
|---|---|---|---|
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Please list any allergies :_____