DYNAMX Physical Therapy

PATIENT MEDICAL QUESTIONNAIRE

Patient Name:	Today's Date:	Date of Birth:	Referring Physician:

What brings you to Therapy Today:

Date of Injury:	How were you injured:

Were x-rays/MRI/CT Scans Taken?: [ ] yes [ ] no	If yes, can you provide date(s) done and any results you might have been told:

Did you have surgery for this condition?: [ ] yes [ ] no	Date of Surgery:	Surgery Performed:
	Surgeon:	

Were you in the hospital in the last 3 days?: [ ] Yes [ ] No	Are you or were you receiving Home Health?: [ ] Yes [ ] No

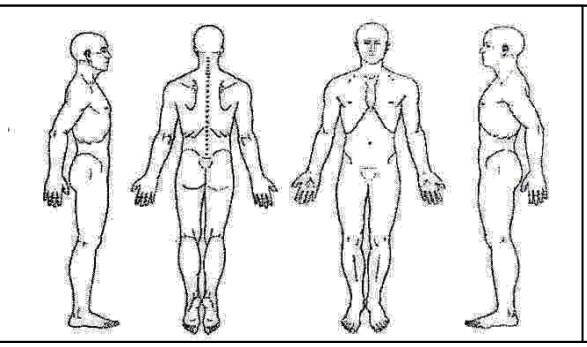
Have you received treatment for this problem: [ ] yes [ ] no
If yes, where: How many treatments did you receive?:

Please list any medications you are taking:

Please note on the body drawings to the right:
1. Where the pain is
2. Where the pain travels to

What makes your pain worse:

Pain is worse: [ ] morning [ ] afternoon [ ] night time



Past Medical History (please mark "yes" if you have been diagnosed with the condition)

High Blood Pressure	[ ] yes [ ] no	Arthritis	[ ] yes [ ] no
Heart Attack	[ ] yes [ ] no	Lung Conditions	[ ] yes [ ] no
Pacemaker	[ ] yes [ ] no	Kidney Disease	[ ] yes [ ] no
Stroke	[ ] yes [ ] no	Hepatitis	[ ] yes [ ] no
Seizure Disorder	[ ] yes [ ] no	AIDS	[ ] yes [ ] no
Diabetes	[ ] yes [ ] no		
Cancer	[ ] yes [ ] no	other:_____	
Pregnant	[ ] yes [ ] no		

Please give information on any "yes" marked above:

Have you fallen down within 3 months? If yes, then please specify. ____Yes, ____No

Please list any surgeries received Not related to this problem:

What are your goals for treatment?:

Patient Signature:_____ Date:_____

Patient Representative:_____ Relationship:_____ Date:_____

Therapist Signature:_____ Lic#:_____ Date:_____