Name: _____ Referring Physician: _____

Nickname: _____ Family Physician: _____

Age: _____ When did you last see the doctor? _____

Weight: _____ Height: _____ When is your next appointment? _____

Who to contact in case of emergency (Include Phone No.): _____

List all medications: _____

Adverse/Allergic reactions: _____

PLEASE CIRCLE HEALTH PROBLEMS PAST OR PRESENT

1. Cardiac
2. Circulatory
3. High Blood Pressure
4. Diabetes
5. Respiratory
6. Cancer
7. Neurological
8. Arthritis
9. Fractures
10. Muscular
11. Endocrine
12. Digestive
13. Bladder
14. Bowel
15. Headaches
16. Dental
17. Visual
18. Communicable/Infectious Diseases
19. OB/GYN
20. Psychological
21. Drug Dependency
22. Alcohol
23. Smoking
24. Sleep Disorder
25. Swallowing Difficulties

Other: _____

Do you have a Pacemaker? Yes ☐ No ☐ Metal Implants? Yes ☐ No ☐

Are you or could you be pregnant at this time? Yes ☐ No ☐

Do you have any sensory changes? Yes ☐ No ☐ (If yes, where?) _____

Surgeries: list type and date _____

_____

Have you ever received Physical, Occupational or Speech Therapy? Yes ☐ No ☐

If so, for what type of problem? _____

ACTIVITY STATUS (Check all that apply)

☐ Working ☐ Homemaker ☐ Volunteer

☐ Student ☐ Retired Other _____

NECK AND BACK PATIENTS ONLY

How do you spend most of your day? (Approximate number of waking hours)

Lying Down _____ Standing _____

Sitting _____ Walking _____

Patient Information

CL30624

ST. Joseph's | Candler
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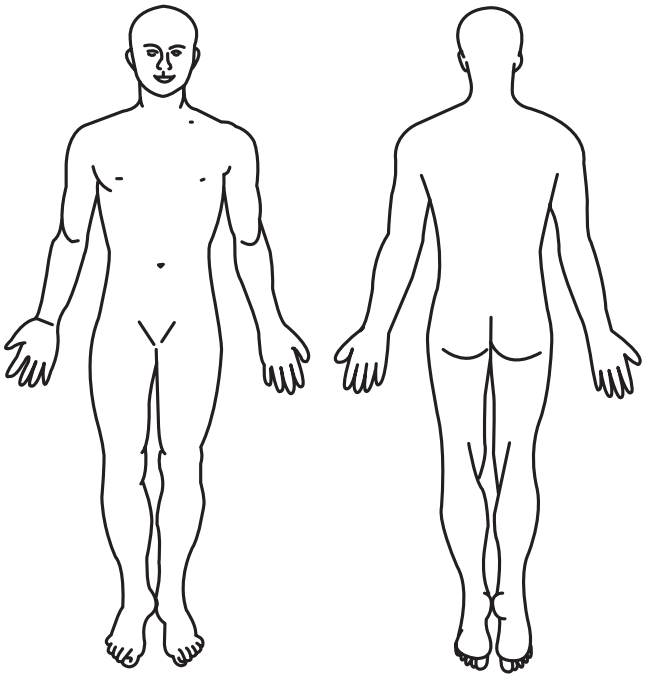
Therapy Outpatient Medical History Questionnaire

Patient Information

Please mark the area of pain



Area and Behavior of Pain:

Initial site of pain: _____

_____

Where is pain now? _____

(See diagram at left)

Rate your pain by circling a number:

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Possible Pain

What are your goals for treatment? _____

_____

_____

_____

Are there any other considerations that your therapist should know? _____

_____

_____

_____

Do you have any medical information located in our health system? Yes ☐ No ☐

If Yes, where? _____

_____