ProCare Physical Therapy and Hand Center, L.L.C.
Medical History Questionnaire

The purpose of this questionnaire is to determine if you might have a medical condition that could effect your treatment here. This information is confidential. Under certain circumstances, we may need to obtain your physician's opinion to determine if you qualify for a particular course of therapy. ***PLEASE take the time to fill this out completely.***

Patient Name: _____ D.O.B.: _____/_____/_____

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Phone #: _____ Alternate Phone #: _____

Who referred you to Therapy? _____

Who is your Primary Care Physician? _____

Please Rate your general health status: (circle one) **Excellent Good Fair Poor**

Current Living Situation (how much assistance do you have at home? Stairs? etc…)

_____

Please describe the problem for which you are here: _____

When did the problem(s) begin? _____/_____/_____ Is it related to a specific injury? **Y / N**

Is it: (circle one) **Improving Getting Worse Staying the Same**

Please describe your pain: (circle one) **Sharp Dull Achy Tingling / Constant Periodic**

Is there anything that relieves your symptoms? If so, what? _____

Have you had this problem before? **Y / N** If so, did the problem get better? **Y / N**

How long did the problem last? _____

Please list any test(s) performed relating to this problem, and the dates of the test(s):

_____

Please list any medications you are currently taking: _____

_____

Using the scale 0=no pain & 10=Emergency Room pain, please mark your current pain level:

0----------10

What type of exercise activities do you participate in, and how often? _____

_____

Height: _____ Weight: _____ Smoker: **Y / N**

Is there any chance that you are pregnant? (circle one) **Y / N**

Do you have a history of:

	Yes	No		Yes	No		Yes	No
High Blood Pressure			Depression			Dizziness		
Heart condition			Seizures			Respiratory Disorders		
Stroke			Cancer			Metal implants		
Diabetes			Falls			Lyme Disease		
Other								

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

Therapist Reviewed: _____ **Date:** _____