kinetix PHYSICAL THERAPY

Name: _____

Date: _____

Medical History Questionnaire

2783 SW 87th Drive, Suite 102, Gainesville, FL 32608
352-505-6665

☐ Male ☐ Female DOB / / Height: _____ Weight: _____

Work Status: ☐Employed ☐Unemployed ☐Disabled ☐ Retired ☐ Student

If employed, doing what: _____

Past Medical History: Check (x) the box next to any illness that applies to you.

☐ Alcoholism	☐ Asthma	☐ Birth Defects	☐ Bleeding disorder	☐ Cancer
☐ Diabetes	☐ Epilepsy	☐ Emphysema	☐ Glaucoma	☐ Radiation
☐ Heart Disease	☐ Hypertension	☐ Kidney Disease	☐ Liver Disorder	☐ Chemotherapy
☐ Sickle Cell anemia	☐ Stroke	☐ Tuberculosis	☐ Ulcers	☐ Lymph Node Removal

☐ Other _____ # removed _____ Area _____

In the past 12 months have you experienced a fall? ☐Yes ☐ No If yes, how many? _____

Previous surgeries: Check (x) the box next to any surgical procedures YOU have had

☐ Appendix	☐ Breast	☐ Colon	☐ Heart	☐ Gallbladder
☐ Hernia (type) _____		☐ Kidney	☐ Ovaries	☐ Prostate
☐ Pacemaker	☐ Stomach	☐ Thyroid	☐ Tonsils	☐ Uterus

☐ Other surgeries: _____

☐ Extremity surgeries: _____

Medications: Please elaborate about any medications YOU are taking currently

Name of drug	How often do you take it	Dosage (mg, mcg, etc.)	Route of Administration (oral, topical, etc.)

Allergies: Do YOU have any allergies to

☐ Medications If yes, please list name(s) of medication(s) _____ ☐ Latex

Have you recently experienced any of the following:

☐ Bowel/bladder dysfunction ☐ Fever ☐ Night Sweats ☐ Unexplained weight loss ☐ Unrelenting night pain
☐ Chest or Heart Pain ☐Other_____

Do you know of any other reason why you should not do physical activity ☐ Yes ☐No

In the past 3 months have you experienced any urinary leakage? ☐ Yes ☐ No

If yes: ☐ with exercise, coughing, laughing, or sneezing
☐ with a strong urge to void

Females: Have you had children? ☐ Yes ☐ No

If yes: # of pregnancies _____ # of deliveries _____ # of C-Sections _____

Are you pregnant now? _____ # of weeks_____

Complications? (Please list): _____

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Name:_____

Date:_____

Current Incident Questionnaire

Explain current problem: _____

_____

Onset Date: / / Injury Date: / / Surgery Date: / /

How did it happen? _____

What treatment have you had for this **current** problem? ☐ Surgery ☐ Injection ☐ Splinting/Bracing

☐ Chiropractic treatment: # of visits: _____ ☐ Massage Therapy: # of visits: _____

What activities make your pain **worse**? _____

What activities make your pain **better**? _____

Have you had **this problem** before: ☐ Yes ☐ No If yes, then when _____

Previous treatment? ☐ Yes ☐ No If yes, then what _____

Diagnostic Tests Completed: ☐**X-Ray** ☐**CT** ☐ **MRI** ☐ **EMG** ☐**Myelogram** ☐**Other** _____

Your current pain:

Indicate on the diagram below the location and nature of your **current** pain according to the following symbols.

Do not indicate areas of pain which are not related to your present problem:

Pain Rating: Scale of 0-10

0 = no pain

10 = worst pain imaginable

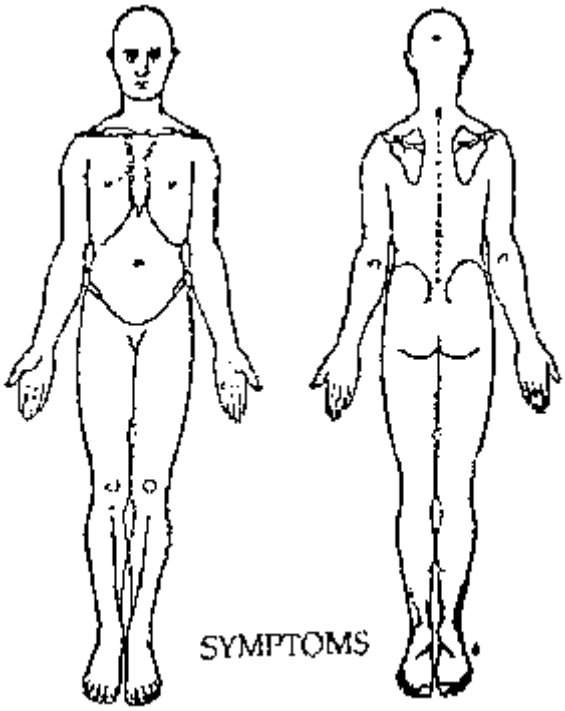
How would you rate the **intensity** of your pain?

Now	0 1 2 3 4 5 6 7 8 9 10	**Intensity is:**
Worst Day	0 1 2 3 4 5 6 7 8 9 10	☐ Increasing
Best Day	0 1 2 3 4 5 6 7 8 9 10	☐ Decreasing
		☐ Unchanged

Pain location/quality: (indicate on diagram)

x x x Dull/aching pain ^ ^ ^ Sharp pain

+ + + Pins and Needles = = = Numbness



Past Level of Function:

<u>Before this problem began</u>, did you have difficulty performing any of your daily activities? If so, please describe:

_____

_____

_____

Exercise prior to this problem: Regularly? ☐ Yes ☐ No

What/how often? _____

Is there a reason why you shouldn't exercise? ☐ No ☐ Yes

If yes, please explain: _____

<u>Since this problem has started</u>, are your complaints affecting your ability to exercise or generally be active? ☐Yes ☐No

With what activities are you having difficulty or experiencing increased pain?

_____

_____

_____

Your goals for treatment are: _____

_____

_____

Thank you for your time in helping us understand your needs better.