HEALTHQUEST

MEDICAL HISTORY/SUBJECTIVE INFORMATION

NAME_____ TODAY'S DATE ____/____/_____

DATE OF BIRTH___/___/___ AGE_____ WEIGHT____ REFERRING PHYSICIAN_____

PAST MEDICAL HISTORY (PLEASE √ ALL THAT APPLY BELOW)

___Heart Attack/Disease	___Diabetes	___High Blood Pressure	___Back/neck injury	___Headaches
___Tuberculosis	___ Arthritis	___Fibromyalgia	___Surgeries	___Osteoporosis
___Asthma	___Epilepsy	___Visually Impaired	___Falls	___Tuberculosis
___Pregnant	___Hepatitis	___Hearing Impaired	___Latex allergy	___Scoliosis
___Joint replacements	___Broken bones	___Numbness/tingling	___Pacemaker	___Smoker
___Pins/metal implants	___Unexplained changes in weight		___Cancer	___Stroke

___Other_____

Any hospitalizations (explain)_____

Allergies: _____

Have you ever had physical/occupational therapy in the past? Y N If yes, please explain_____

Do you have any restrictions to exercise due to your current problem or medical history? _____

Have you had surgery for your condition? Y N If yes, please give approximate date_____

Have you had any injections for your condition? Y N If yes, please give approximate date_____

Please list any medications that you are taking _____

_____

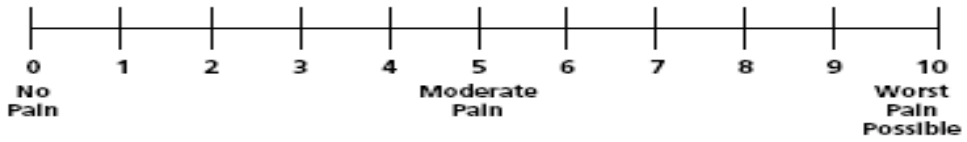
What are your current symptoms _____

When and How did your injury occur? _____

What do you hope to accomplish with therapy? _____

PAIN

Rate your pain from 0 – 10



Where is your pain located? _____

What makes your pain better? _____

What makes your pain worse? _____

Does the pain interfere with your daily life? Y N

If yes explain_____

_____

Please check boxes below that currently cause you difficulty:

☐lying down	☐walking	☐driving	☐dressing	☐sitting
☐stairs	☐overhead activities	☐meal prep	☐standing	☐lifting/carrying
☐house work	☐sleeping			

HEALTHQUEST

EMPLOYMENT HISTORY

Are you currently working: Y N

If no, how many total days of work have you missed?_____

What do you do for work?_____

What are your work duties? _____

Does your current condition affect your ability to work? Y N If yes, explain _____

_____

OTHER

When are you scheduled to see your doctor again? _____

What type of non-work activities are you involved in? _____

PATIENT SIGNATURE: _____

THERAPIST SIGNATURE: _____

THERAPIST'S COMMENTS: _____

_____

_____

_____