

RECOVERY ZONE PHYSICAL THERAPY MEDICAL QUESTIONNAIRE

NAME _____ AGE _____ DATE _____

I am here for this problem: _____

This problem began on: _____.

It was / was not the result of work. _____

I want to achieve the following goals as a result of my physical therapy (must be functional & measurable):

Example: walk 500 feet around grocery store. Jog 1/2 mile.

1. _____ 4. _____

2. _____ 5. _____

3. _____

Please answer all questions that apply to you.

I take these prescription medications: _____

I take these over the counter drugs (Tylenol, Aspirin, or Maalox): _____

Allergies: _____

Surgeries (what/date): _____

Previous Injuries: _____

I have or had these medical problems:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Arthritis	___	___	Cancer	___	___	Diabetes	___	___
Fibromyalgia	___	___	Depression	___	___	Indigestion	___	___
HIV (exposure)	___	___	Hepatitis (type) _____	___	___	M/S	___	___
Ulcerations	___	___	Headaches	___	___	Neck Pain	___	___
Low Back Pain	___	___	Head Injury	___	___	Trouble Sleeping	___	___
Muscle Spasms	___	___	High Blood Pressure	___	___	Heart Problems	___	___
Parkinson's	___	___	Pacemaker	___	___			

History of Cancer? _____ Dates: _____

I smoke (how much): _____ Spinal Cord Injury (date & level): _____

Number of babies I've had: _____ Dates: _____

My periods stopped (menopause/hysterectomy) Date/Year: _____

If here for incontinence, painful intercourse or impotence, please answer any of the following that apply:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Bladder Trouble	___	___	Testicle / Scrotum	___	___
Bladder Infections	___	___	discomfort	___	___
Burning /Pain w/Urination	___	___	Painful Intercourse	___	___
Frequent Urination	___	___	Pain During Erection	___	___
Urine/Fecal Leakage	___	___	Low Sperm Count	___	___
Constipation	___	___	Maintaining Erection	___	___
Diarrhea	___	___	Trouble achieving orgasm	___	___