

THRIVE PHYSICAL THERAPY

MEDICAL QUESTIONNAIRE

PATIENT'S NAME: _____ DATE: _____

HAVE YOU EVER EXPERIENCED ANY SYMPTOMS LIKE THIS BEFORE? _____ NO _____ YES

WHEN DID YOUR SYMPTOMS START (PRIOR TO SURGERY IF APPLICABLE) _____

WHAT HAPPENED? HOW DID IT START? _____

HAVE YOU RECEIVED PREVIOUS PHYSICAL THERAPY OR OTHER TREATMENT FOR THIS PROBLEM?

_____ NO _____ YES

(IF YES, WHAT AND WHEN) _____

(IF YES, WAS IT HELPFUL?) _____

WHEN ARE YOU MOST AWARE OF YOUR SYMPTOMS?

_____ A.M _____ PM _____ END OF DAY _____ OTHER _____

IS YOUR PROBLEM: _____ GETTING WORSE _____ GETTING BETTER _____ STAYING THE SAME

WHAT ACTIVITIES/POSITIONS **INCREASE** YOUR PAIN?

WHAT ACTIVITIES/POSITIONS **DECREASE** YOUR PAIN?

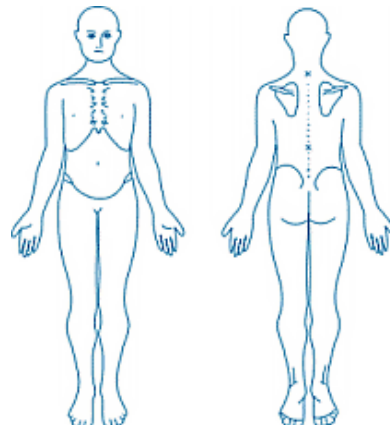
PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

PLEASE LIST ANY PAST OR CURRENT HEALTH PROBLEMS (HEART PROBLEMS, CANCER, DIABETES, HIGH BLOOD PRESSURE, ETC.)

HAVE ANY DIAGNOSTIC TESTS BEEN TAKEN? (X-RAY, MRI, EMG, ETC.) _____ YES _____ NO
IF YES, PLEASE LIST TYPE OF TEST, DOCTOR WHO ORDERED THE TEST AND DATE OF TEST:

PLEASE PLACE THE FOLLOWING SYMBOLS ON THE PICTURE TO INDICATE WHERE YOUR PROBLEM IS:

XX = PAIN
NN = NUMBNESS
TT = TINGLING



PATIENT SIGNATURE _____