UPPER PERK PHYSICAL THERAPY & SPORTS REHAB., INC./
NEW HOPE PHYSICAL THERAPY & SPORTS REHAB.
MEDICAL QUESTIONNAIRE

Name _____ Referring Physician _____
Family Physician & phone number: _____
Date of Dr. Visit for this injury: _____ Last date worked due this injury: _____
Is an attorney involved: YES or NO Have you had surgery for this injury: YES or NO
If yes, date of surgery: _____ Type of surgery: _____
Please list all allergies: _____

PRESENT PAIN SCALE FOR INJURY/ SURGERY (OUR OF 10 – 10 BEING YOUR WORSE PAIN): _____

Have you had any of the following medical services for this injury/ surgery? (check YES or NO)

	YES	NO		YES	NO
Speech Therapy	____	____	Home health care	____	____
Chiropractor	____	____	CT Scan	____	____
EMG/ NCV	____	____	General Practioner	____	____
Massage Therapy	____	____	MRI	____	____
Myelogram	____	____	Neuologist	____	____
Occupational Therapy	____	____	Orthopedist	____	____
Emergency Room Care	____	____	X-rays	____	____
Hospital Stay	____	____	Skilled Nursing Facility Stay	____	____

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO
Asthma/Bronchitis/Emphysema	____	____	Severe or Frequent Headaches	____	____
Shortness of breath/Chest pain	____	____	Vision or hearing	____	____
Coronary heart disease or Angina	____	____	Numbness or Tingling	____	____
Do you have a pacemaker?	____	____	Dizziness of Fainting	____	____
High Blood pressure	____	____	Bowel or bladder problems	____	____
Heart attack or heart surgery	____	____	Weakness	____	____
Stroke/TIA	____	____	Weight loss/ Energy loss	____	____
Congestive heart failure	____	____	Hernia	____	____
Blood clot/Emboli/DVT	____	____	Varicose Veins	____	____
Epilepsy/Seizures	____	____	Allergies	____	____
Thyroid disease or Goiter	____	____	Mental implants or pins	____	____
Anemia	____	____	Joint replacement surgery	____	____
Infectious disease	____	____	Neck injury/surgery	____	____
Diabetes	____	____	Shoulder injury/surgery	____	____
Cancer or Chemo/Radiation	____	____	Elbow/Hand surgery	____	____
Osteoporosis	____	____	Knee injury/surgery	____	____
Gout	____	____	Leg/Ankle/Foot injury/surgery	____	____
Sleeping difficulties	____	____	Are you pregnant?	____	____
Emotional/Psychological problems	____	____	Do you use tobacco?	____	____

Is there any additional information that would assist us with your care? _____

_____

What are your rehabilitation expectations/goals while in this program? _____

_____

Patient/Guardian Signature: _____ Date: _____