DYNAMIC BRACING & PHYSICAL THERAPY

Patient Medical Questionnaire

Name: ______________________________ Age: ________ Height: ________ Weight: __________

What are your symptoms? ____

Date of onset (and surgical date if applicable): ____

1) How did the pain start?
☐ Injured at work ☐ Auto accident ☐ Overuse
☐ Surgery ☐ Sports/Rec ☐ Fall
☐ Unknown ☐ Other: ____________________

2) Did the pain start: ☐ Gradually ☐ Suddenly

3) Since the onset is the pain:
☐ Worse ☐ Better ☐ Stays the same

4) As the day progresses is the pain:
☐ Worse ☐ Better ☐ Stays the same

5) Place an **X** on the scale for the **LEAST** pain you experience and for the **MOST** pain you experience. Put an **A** on the scale for what it is most consistently, on **AVERAGE**.

[____]
0 10
Least Most

6) Pain description:
☐ Sharp ☐ Burning ☐ Cramping
☐ Dull/Achy ☐ Shooting ☐ Spasm
☐ Throbbing ☐ Periodic ☐ Constant
☐ Dizziness ☐ Numbness ☐ Tight
☐ Stiff ☐ Unstable

7) When is the pain **BETTER** or decreased?
☐ Lying down ☐ Pain pills
☐ Sitting ☐ Manipulation
☐ Standing ☐ Injections for pain
☐ Walking ☐ Muscle relaxant pills
☐ Heat ☐ Massage
☐ Cold ☐ Mornings
☐ Exercises ☐ End of day
☐ Sleeping/Night ☐ Movement
☐ Aspirin/Anti-inflammatory pills
☐ Other: ______________________________

8) When is the pain **WORSE** or increased?
☐ Lying down ☐ Sitting
☐ Walking ☐ Standing
☐ Massage ☐ Manipulation
☐ Exercise ☐ Mornings
☐ Cold ☐ Sleeping/Night
☐ Heat ☐ End of day
☐ Movement ☐ Cough/Sneeze/Breathe
☐ Other: ______________________________

9) List recreational/leisure/employment activities that are difficult for you to do.

____

____

10) Check all diagnostic studies you have had for this problem:
☐ X-Rays ☐ CT scan ☐ MRI/MRA
☐ EMG ☐ Injections ☐ Bone scan
☐ Bone density scan

11) What types of healthcare providers have you seen for this condition?
☐ Chiropractor ☐ Massage Therapist
☐ Physical Therapist ☐ Neurologist/Neurosurgeon
☐ Orthopedic Surgeon ☐ Physiatrist
☐ Counselor/Psychologist
☐ Other: ______________________________

12) Please check all the following conditions that apply to you either presently or in the past:
☐ Alzheimer's ☐ Cancer or history of cancer
☐ Cardiovascular disease ☐ Immunosuppression
☐ CVA/Stroke ☐ Lupus
☐ Current infection ☐ Muscular dystrophy
☐ Diabetes - Type: ____ ☐ Osteoarthritis
☐ Fibromyalgia ☐ Parkinson's
☐ Fracture ☐ Rheumatoid arthritis
☐ High blood pressure ☐ Traumatic Brain Injury
☐ Osteopenia ☐ Osteoporosis
☐ Bladder problems ☐ Bowel or digestive issues
☐ Emotional/Psychological: ____________________
☐ History of falls (date of most recent): ______________
☐ Other: ______________________________

13) Please list all surgeries and approximate dates:

____

____

____

14) Please list all current medications (or attach list):

____

____

____

15) Please list allergies (or attach list):

____

16) Have you had a similar problem in the past?
☐ No ☐ Yes Please describe:
____
____

17) Does the pain wake you at night? ☐ No ☐ Yes

18) In what position do you sleep? ____________________

19) How would you describe your general health?
____

20) Do you smoke cigarettes? ☐ No ☐ Yes PPD ______

21) Have you: ☐ Gained ☐ Lost weight recently? ☐ No
If so, how much? ________________________________

22) Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following:

☐ Cancer ☐ Heart disease ☐ Diabetes
☐ Tuberculosis ☐ Mental disorder ☐ Blood pressure
☐ Arthritis ☐ Kidney disease ☐ Stroke

23) Participation in Sports/Recreational Activities

☐ 1-2x/week ☐ 3-4x/week
☐ 5x or more/week ☐ Occasional
☐ Not regularly ☐ None

Type:

☐ Walking ☐ Running
☐ Swimming ☐ Biking
☐ Aerobics ☐ Weightlifting
☐ Stretching ☐ Yoga
☐ Other: ____________________________________

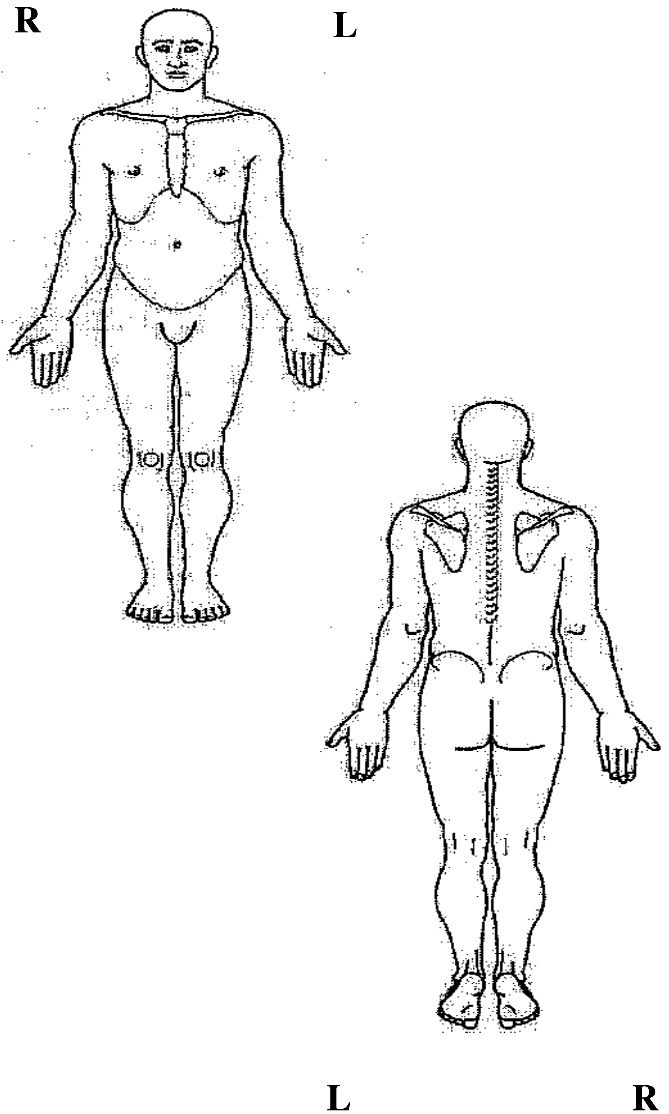
24) Occupation: ________________________________

GOALS: What can we help you do through physical therapy?
____
____
____

Is there anything else you'd like us to know about your condition that wasn't addressed in this questionnaire?
____
____
____
____

Please mark on the body chart your areas of pain using the following symbols:

X = Pain **0** = Numbness and tingling
* = Weakness



How did you hear about Dynamic Bracing & Physical Therapy?
____

Patient Signature:______________________________

Print Name: ___________________________________

Date: ________________