208 Dixie Drive Clute, TX 77531 P:979-265-2755 F:979-265-2756 maxrehabsport.com

Patient Information

Name:_____ Gender:_____ Email:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Home Phone #:_____ Cell #:_____ Work #:_____

Date of Birth:_____ Social Sec #:_____ Marital Status:_____

Emergency Contact:_____ Relationship:_____ Phone #:_____

Referring Physician:_____ Phone #:_____

Primary Care Physician:_____ Phone #:_____

Medical History Questionnaire

Chief Complaints

Describe the problem(s) for which you seek therapy:

Balance Problems

Burn

Difficulty Walking

Difficulty with Daily Activities

Dizziness

Fall/History of Falls

Fatigue/Poor Endurance

Headache

Impaired Sensation

Joint Stiffness

Joint Swelling

Muscle Tenderness

Muscles Weakness

Numbness

Pain

Shortness of Breath

Tingling

Ulcer/Wound/Other Skin Condition

Other: _____

Other: _____

If there is pain, specify where you have pain and what type of pain you have

Ankle Pain_____

Back Pain_____

Chest Pain_____

Elbow Pain_____

Foot Pain_____

Hand Pain_____

Hip Pain_____

Knee Pain_____

Leg Pain_____

Neck Pain_____

Rib Pain_____

Shoulder Pain_____

Arm Pain_____

Wrist Pain_____

History of Current Complaint

When did the current problem(s) begin? (MM/DD/YYYY)_____

Date of Injury _____

Describe history of the current complaint(s)

_____

_____

_____

Onset of current condition:

Unspecified

Gradual

Traumatic (whiplash, fall, blow)

Other, Please specify: _____

How are you taking care of the current problem(s) now?

_____

_____

_____

Are you seeing anyone else for the problem(s)?

Acupuncturist
Athletic Trainer
Cardiologist
Chiropractor
Dentist
Family Practitioner
Internist
Massage Therapist
Neurologist
OB GYN
Occupational Therapist
Orthopedist
Osteopath
Pediatrician
Physiatrist (Physical Medicine and Rehab)
Physical Therapist
Podiatrist
Primary Care Physician
Psychologist
Social Work
Speech-Language Pathologist

Has this problem occurred before? (YES/NO) If yes, did the problem(s) get better? (YES/NO)

Start Date / End Date: _____

Did you see anyone the previous episode? (YES/NO) If yes, who did you see & how long did they treat you? _____

_____

How long did the problem(s) last? _____

Have you had a change in status since last episode? _____

Recent Hospitalizations (Dates / Locations):

_____

_____

I am concerned about or have problems with:

Bed mobility

Climbing stairs

Coordination

Difficulty with self-care (such as bathing, dressing)

Flexibility

Grasping objects/lifting

Performing home management (household chores, shopping, care of dependents)

Preforming sports recreation, and play activities

Sitting

Standing

Transfers (getting out of chair, bed)

Walking

Writing/grasping items with hands

Other: _____

Associated Surgery

Associated Surgeries and Dates:

_____

_____

Pain Scale (0= no pain, 10 = emergency room pain)

BEST:

{|--------|---------|---------|---------|---------|---------|---------|---------|---------|---------|}

0 1 2 3 4 5 6 7 8 9 10

WORST:

{|--------|---------|---------|---------|---------|---------|---------|---------|---------|---------|}

0 1 2 3 4 5 6 7 8 9 10

PRESENT:

{|--------|---------|---------|---------|---------|---------|---------|---------|---------|---------|}

0 1 2 3 4 5 6 7 8 9 10

How would you describe your activity tolerance? (Excellent / Good/ Fair / Poor)

What activities make your symptoms worse?

_____

_____

What activities make your symptoms better?

_____

_____

Health Condition(s)

Cardiopulmonary (Heart Issues)

Musculoskeletal (Orthopedic, Joint Problems, Muscle Problems)

Neuromuscular (Nerve Issues)

Pediatric (Delay, Disorders, Syndromes)

Women's Health

Integumentary (Skin Disorders / Issues)

Geriatrics (Alzheimer's, Dementia, Diabetic Neuropathy)

Other: _____

Please explain:

_____

_____

Medical History Screening

Abdominal problems
Anxiety
Bowel problems
Chest pain
Constant pain in body
Coordination problems
Cough
Difficulty or change in swallowing
Difficulty sleeping
Difficulty walking
Dizziness
Excessive thirst
Fainting spells
Fever/ chills/ sweats
Foot pain/ discoloration
Frequent heartburn or indigestion
Frequent headaches
Hearing impairment
Heart palpitations
Hoarseness or changes in speech
Joint pain, swelling or redness
Loss of appetite
Loss of balance or falling
Loss of pleasure in things usually enjoyed
Nausea/vomiting
Numbness or changes in sensation
Pain at night
Pain or cramping in lower leg
Prolonged fatigue
Seizures
Sexually transmitted disease
Shortness of breath
Stress
Unusual lumps or growths
Urinary problems
Vision problems
Weakness in arms or legs
Weight loss/gain
Other

Medical History

Arthritis
Asthma
Broken bones/ fracture
Cancer
Cellulits
Communicable disease
High blood pressure
Infectious disease
Kidney problems
Liver disease
Low back pain
Lymphedema

Congestive heart failure
Circulation/ vascular problems
COPD
Deep vein thrombosis
Depression
Developmental or growth problems
Diabetes
Eating disorder
Emphysema
Stroke/ TIA
Fibromyalgia
GERD
Head injury
Heart attack/ MI
Heart disease
Hearing impairment
High cholesterol

Multiple sclerosis
Muscular dystrophy
Obesity
Osteoarthritis
Osteoporosis
Parkinson disease
Peripheral neuropathy
Psychiatric disorders
Repeated infections
Seizures/ epilepsy
Spinal cord injury
Skin diseases
Stomach problems
Swallowing difficulty
Thyroid problems
Vision impairment
Other: _____

Surgical History/ Allergies/ Medications

Please list past surgeries:

_____
_____
_____
_____

Do you have metal or plastic in your body? Is so, where?

_____
_____
_____
_____

Please list Allergies and Reactions:

_____
_____
_____

Please list medications:

Prescription

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Non-Prescription

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____