ELITE PHYSICAL THERAPY, LLC

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MEDICAL QUESTIONAIRE

Name: _____ **Approximate Date of Injury/Symptoms:** _____

Circle "Yes" or "No" as it applies to your medical history and comment as needed.

Yes	No	AIDS or HIV	Yes	No	Fractures/Broken Bones
Yes	No	Allergies/Sinus	Yes	No	Heart Disease/Condition
Yes	No	Diabetes	Yes	No	Cancer (Active or Remission)
Yes	No	Dizziness/Vertigo	Yes	No	Low Blood Pressure
Yes	No	Stroke/TIA	Yes	No	High Blood Pressure
Yes	No	Blood Clots	Yes	No	Rheumatoid Arthritis
Yes	No	Seizure Disorder	Yes	No	Osteoarthritis
Yes	No	TMJ	Yes	No	Artificial Joints
Yes	No	Hepatitis (A, B, or C)	Yes	No	Hypothyroidism
Yes	No	Circulatory Problems	Yes	No	Hysterectomy
Yes	No	Cesarean	Yes	No	Osteoporosis/Osteopenia

Comments: _____

_____

Please list any medications you are taking.

_____

_____

Please list all surgeries including dates when they were done.

_____

_____

Please circle all special tests that have been performed for your condition and comment as needed.

X-ray	CT Scan	Bone Scan	Discogram	Nerve Conduction (EMG)
MRI	Arthrogram	Sonogram	Myelogram	Bone Density Study

Comments: _____

_____

Please circle the words that best describe your symptoms.

Sharp	Dull	Deep	Catching	Electric	Sweaty
Buzzing	Throbbing	Aching	Weak	Sickening	Burning
Shooting	Heavy	Tired	Gnawing	Cold	Numb
Asleep	Nagging				