PRESERVA
THERAPY GROUP

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MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **DOB**: / /

Weight: _____ **H**eight: _____ **S**ex: ☐ **M** ☐ **F**

Why are you here? _____

_____

DIAGNOSIS:

_____

_____

Past Medical History:

_____

_____

☐ COPD	☐ Asthma	☐ Birth Defects	☐ Bleeding Disorder	☐ Cancer	☐ Diabetes
☐ Emphysema	☐ Arthrosis	☐ Radiaton	☐ Heart Disease	☐ Hypertension	☐ Kidney Disease
☐ Liver Disorder	☐ Stroke	☐ Ulcers	☐ Chemotherapy	☐ Tuberculosis	☐ Hepatitis

In the past 3 months have you experienced any urinary leakage? ☐ **Y**es ☐ **N**o

In the past 12 months have you experienced a fall? ☐ **Y**es ☐ **N**o **I**f yes, how many? _____

Previous Surgeries:

_____

_____

☐ Appendix	☐ Breast	☐ Colon	☐ Gall Bladder	☐ Heart	☐ Kidney
☐ TKR	☐ THR	☐ Back Surgery	☐ Stomach	☐ Thyroid	☐ Tonsils
☐ Ankle/Foot (type) _____		☐ Shoulder (type) _____		☐ Hernia (type) _____	

Medications:

Name of Drug	**H**ow often do you take it	**D**osage (mg, mcg, etc.)	**R**oute of Administration(oral, etc)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies:

Please list name of Allergies: _____

_____

Explain: _____

Family History:

☐ COPD ☐ Cancer ☐ Diabetes ☐ Gout ☐ Heart Disease
☐ Rheumatoid Arthritis ☐ Arthritis ☐ Sickle Cell anemia ☐ Other: _____

How far can you walk? _____ ☐ **D**o you need oxygen? ☐ **Y**es ☐ **N**o

Do you frequently feel pain in your chest or heart? ☐ **Y**es ☐ **N**o **D**o you smoke? ☐ **Y**es ☐ **N**o
Do you have difficulty in speaking? ☐ **Y**es ☐ **N**o **D**o you have difficulty in swallowing? ☐ **Y**es ☐ **N**o
Who do you live with? _____ **D**o you have stairs to do everyday? ☐ **Y**es ☐ **N**o
Do you use an assistive device? ☐ **W**alker ☐ **C**ane ☐ **Q**uadcane **D**o you drive? ☐ **Y**es ☐ **N**o

Explain current problem:

_____

_____

Injury date: / / **S**urgery Date: / / **H**ow did it happen?: _____

_____

What treatment have you had for this current problem? ☐Surgery ☐Injection ☐Splinting/Bracing
☐Chiropractic Treatment: # of visits: _____ ☐ Massage Therapy: # of visits: _____
What activities make your pain worse? _____
What activities make your pain better? _____
When are your problems most severe? ☐ Morning ☐ Afternoon ☐ Evening ☐ Consistent all day
What is your normal sleeping position? ☐ Stomach ☐ Sidelying ☐ Back
Have you had this problem before? ☐ Yes ☐ No If yes, when _____
Have you had a previous treatment? ☐ Yes ☐ No If yes, what _____

Pain Rating: Scale of 0-10 0 = no pain 10 = worst pain imaginable

How would you rate the intensity of your pain?		**I**ntensity is:
Now	0 1 2 3 4 5 6 7 8 9 10	☐Incresaing
Worst Day	0 1 2 3 4 5 6 7 8 9 10	☐Decreasing
Best Day	0 1 2 3 4 5 6 7 8 9 10	☐Unchanged

Before this problem began, did you have difficulty performing any of your daily activities? If so, please describe: _____

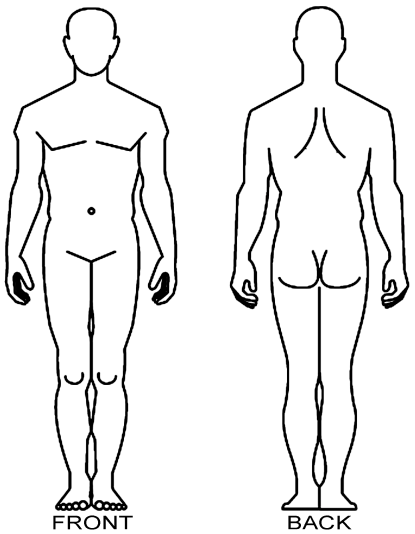
_____

Exercise prior to this problem/what, how often: _____

_____

_____

_____



PAIN LOCATION

xxx Dull/Aching Pain ^^^ Sharp Pain
+++ Pins and Needles === Numbness

Therapyst Notes

_____

_____

_____ _____

Patient or Legal Rapresentative's **S**ignature **D**ate