Buffalo Niagara Physical Therapy
Medical History Questionnaire

Name:_____ Referring MD:_____ Date:_____

Have you ever had: X-Ray MRI CT Scan Doppler Ultrasound EMG/NCV other
Results:

PLEASE CIRCLE ALL HEALTH PROBLEMS PAST AND/OR PRESENT:

Cardiac	Pacemaker	High Blood Pressure	Diabetes	Respiratory	Cancer
Neurological	Arthritis	Fracture(s)	Muscular	Endocrine	Digestive
Bladder	Bowel	Headaches	Dental	Visual	OB/GYN
Smoking	Psychological	Drug dependency	Alcohol	Sleep Disorder	Metal Implants
Communicable/Infectious Disease		Swallowing Disorder	Circulatory	Allergies	other

Height:_____ Weight:_____ Usual Blood Pressure: _____

Medications:_____

_____

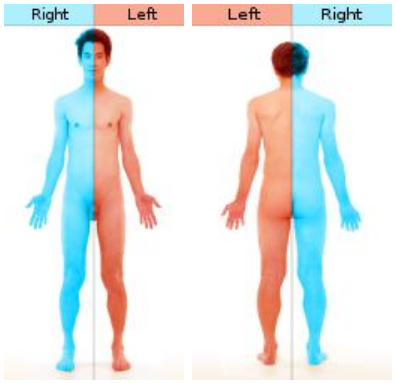
Surgical History (Type and dates): _____

_____

Have you ever received Physical, Occupational, or Speech Therapy? YES NO
If YES, for what type of problem?_____

What are your goals for Physical Therapy?_____

Please mark area of pain (current) Level of pain (1-10 pain scale):_____ Initial Site:_____



Patient Signature:_____ Date:_____