kintsugi
PHYSICAL THERAPY & WELLNESS

INITIAL QUESTIONAIRE AND MEDICAL HISTORY

Name:
Age:
Date:

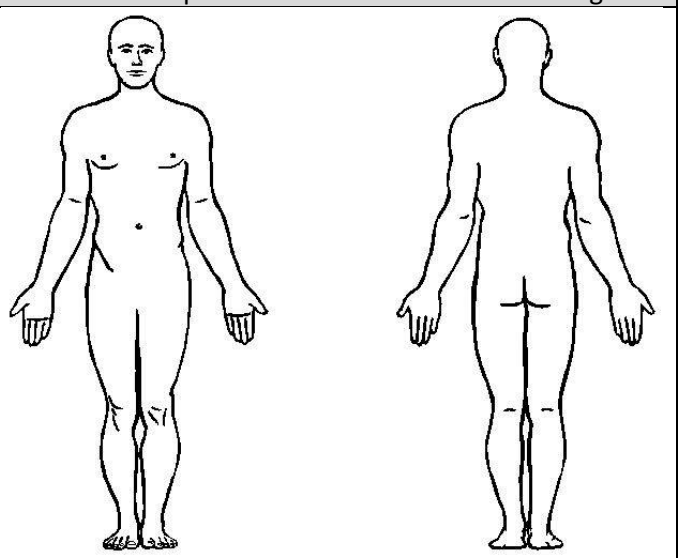
What is the reason for your visit today?	
Date of injury / onset of symptoms:	
Date of surgery (if applicable)	

Where did your injury occur? Work Auto Home NA-Gradual onset Other:

Which best describes how your injury occurred?

Cumulative trauma/overuse
Degenerative process
Fall
Lifting
MVA
Sports/Recreation
Trauma
Unknown/Gradual onset

Shade areas of pain or discomfort on the below figure



Since onset, are your symptoms: (circle one)

Improving Worsening Not changing

Frequency of symptoms: (circle one)

Constant Intermittent/Daily Occasional

Nature of symptoms. Circle all that apply.

Burning
Dull/Achy.
Numbness/Tingling
Sharp
Shooting
Throbbing

When is you pain worst?

Morning Evening Neither

Please rate your pain on a scale of 0 to 10: At Present_____ Lowest (last 24 hours)_____ Highest (last 24 hours)___

0 = no pain 1,2,3 = low pain 4,5,6 = moderate pain 7,8,9 = intense pain 10 = emergency

What aggravates your symptoms? Circle all that apply.

Coughing/Sneezing	Lifting	Repetitive Activities	Stress
Driving	Looking up overhead	Running	Sustained bending
Getting dressed	Reaching behind back	Sitting	Taking a deep breath
Going to /rising from sitting	Reaching out from body	Sleeping	Walking
Household activities	Reaching overhead	Stairs	
Kneeling/Squatting	Recreation/Sports	Standing	

Do your symptoms wake you up at night? NO YES If yes, how often?

If YES, do you wake: While laying still Only when changing positions Both

What relieves your symptoms? Circle all that apply

Changing positions	Heat	Rest	Stretching
Cold	Message	Sitting	Walking
Exercise	Medication	Splint/Wearing brace	Nothing relieves my Symptoms

Since the onset of your current symptoms, have you experienced an of the below? Circle all that apply.

Abdominal Pain	Dizziness/Lightheadedness	Heart burn/Indigestion	Persistent cough
Bowel/Bladder changes	Fainting.	Muscle weakness.	Recent infection
Difficulty swallowing	Fever/Chills/Sweats	Nausea/Vomiting.	Unexplained weight loss
Difficulty walking.	Headaches.	Night pain.	Vision Changes

Have you had any of the below tests for this condition? Circle all that apply.

X-ray	MRI	FCE/IME	Test results if known:
Arthrogram	CT scan	Other:	

Please indicate any previous or current treatment you have had related to your current injury. Circle all that apply.

Chiropractic/Osteopath	Massage Therapy	Occupational Therapy	Other:
Injection	Medication	Physical Therapy	None

PLEASE COMPLETE THE OTHER SIDE

WORK HISTORY			
Are you currently employed?	YES NO. Retired. Student		
Occupation:			
If injured on the job or with is affected by your current symptoms, please fill out the next three sections.			
Are you currently working?	YES/Full duty. YES/Light duty. NO/Last day of duty		
Are you planning to return to your job of injury?	YES NO. Unsure		
If no, has an alternate job goal been identified for you?	NO/I don't know Yes, the new goal is:		
MEDICAL HISTORY			
At the present time, would you say that your health is:	Excellent Good Fair Poor		
Please indicate if you have had any prior injuries to the following joints. Circle all that apply.			
Ankle Back Elbow Foot Hand Hip Knee Neck Shoulder			
Please indicate if you have had or currently have any of the below medical conditions. Circle all that apply.			
Allergies	Face/Ear/Jaw pain	Kidney disease	Pregnant (currently)
Anemia	Fibromyalgia	Latex of tape allergy	Rheumatoid arthritis
Asthma	Gout	Liver disease	Shortness of breath
Back/Neck pain	Heart Disease	Migraines	Skin Condition
Blood clots	Hepatitis	Multiple Sclerosis	Stroke / TIA
Cancer	Hernia	Osteoarthritis	Swelling in the feet /legs
Chest pain	Hight blood pressure	Osteoporosis	Thyroid issues
Depression	HIV+/AIDs	Pacemaker	Tuberculosis
Diabetes	Imbalance	Parkinson's	
Epilepsy / Seizures	Incontinence	Polio	
Please list and other medical conditions we should know about:			
Please list and surgeries you have had:			
Have you had any major illnesses/hospitalizations in the last year? YES NO If yes, please describe below:			

MEDICATIONS: Please list all medications you are taking including dosage, frequency, and route to administration. Include all prescriptions, over-the-counter, herbal/vitamin/mineral supplements. Please complete to the best of your ability, If you have a list, please give it tour of front office so that they may make a copy.

[ ] Please see attached list. [ ] I am not taking any medications, vitamins, or supplements.

Name	Dosage	Frequency	Route of Administration
		1 2 3 4x/day PRN	Oral Injection Other
		1 2 3 4x/day PRN	
		1 2 3 4x/day PRN	
		1 2 3 4x/day PRN	
		1 2 3 4x/day PRN	
		1 2 3 4x/day PRN	
		1 2 3 4x/day PRN	
		1 2 3 4x/day PRN	
		1 2 3 4x/day PRN	

Have you had any falls in the last 12 months?		YES NO	
If yes, how many?		Did you injure yourself in any of those falls?	YES NO
Do you currently use any type of tobacco products?			

_____ _____

Patient or Guardian Signature Date

For office use only: Heart rate_____ Blood Pressure_____ Taken by:_____