West Billings Physical Therapy & Sports Medicine Medical Questionaire

Print Name: ______________________________ Date: ____________

Please list any medical conditions now or previously (i.e. history of cancer):

List anything you think we should be aware of. For example: diabetes, blood clots, heart problems, pacemaker or other indwelling electrical devices, cancer, seizure disorder, etc.

List any surgeries you have undergone:

List any medications you are currently taking:

List your current activity level:

- ❑ Sedentary (no exercise)
- ❑ Mild exercise (golf, use stairs)
- ❑ Occasional vigorous exercise
- ❑ Regular vigorous exercise

List all specialists you are seeing for THIS condition:

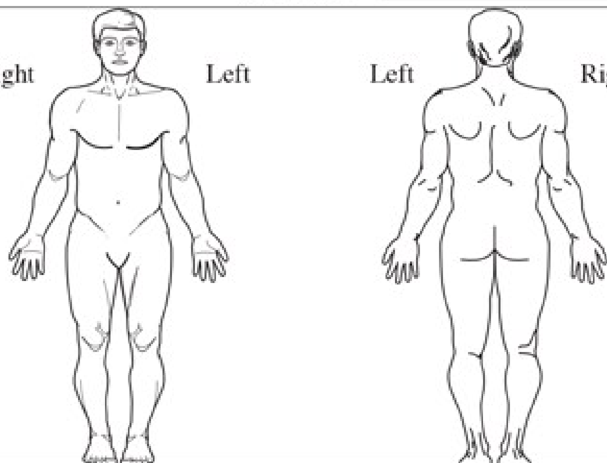
- ❑ Medical doctor
- ❑ Physician Assist or Nurse Practitioner
- ❑ Naturopathic
- ❑ Chiropractor
- ❑ Other

List diagnostic tests you have undergone for THIS conditon:

- ❑ X-ray
- ❑ MRI
- ❑ CT scan
- ❑ EMG
- ❑ Other ____________

Are you pregnant? ❑ Yes ❑ No

Do you have a latex allergy or are you allergic to bananas? ❑ Yes ❑ No



Rate your pain on average throughout your day: _____/10

At worst: _____/10 **At best:** _____/10

(0 = no pain, 10 = worst imaginable)

Using the descriptors below, please indicate on the drawing where you are currently experiencing pain.

Key:

00	Pins & Needles
xx	Burning
//	Stabbing
==	Numbness
""""	Aching
↑↓	Shooting