Powhatan **Physical Therapy**

MEDICAL INFORMATION FORM

Name: _____ **Date:** _____

What brings you to see us today? _____

_____

_____

_____

_____

If we are seeing you for a painful condition, how long have you been experiencing pain?

_____

1. **Was this due to a personal injury?** ☐ Yes ☐ No
2. **Was this due to an auto accident?** ☐ Yes ☐ No Accident State: _____
3. **Was this due to a work-related accident?** ☐ Yes ☐ No
4. **Describe how you were hurt** _____

_____

_____

_____

_____

5. **On the scales below, please circle the number which best represents the severity of your pain.**

Average for the last 48 hours:

No Pain — Worst Pain Imaginable

0 1 2 3 4 5 6 7 8 9 10

Best for the last 48 hours:

No Pain — Worst Pain Imaginable

0 1 2 3 4 5 6 7 8 9 10

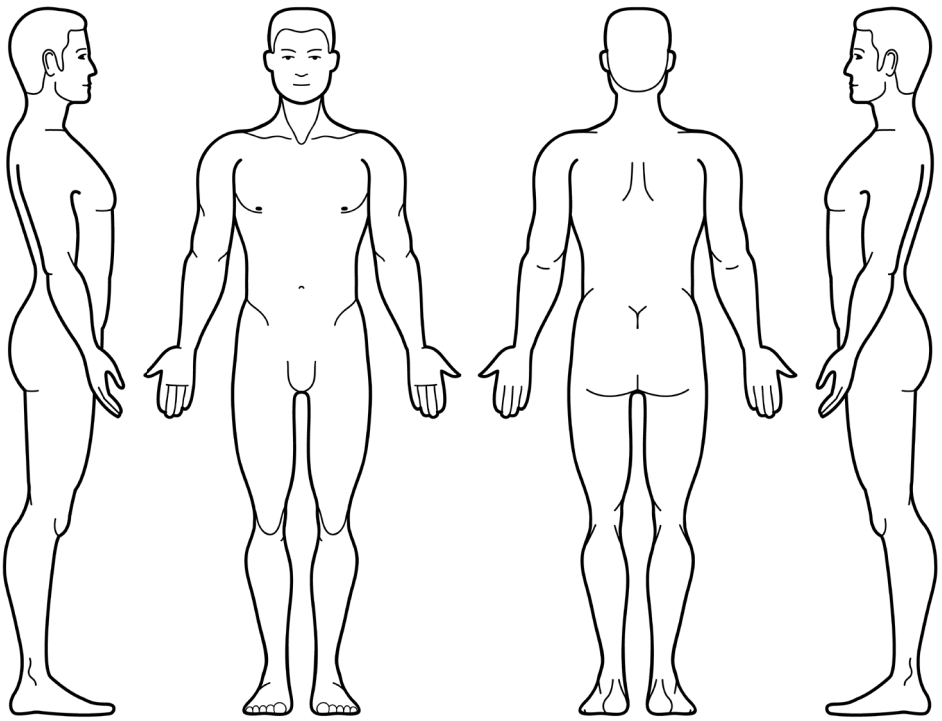
Worst for the last 48 hours:

No Pain — Worst Pain Imaginable

0 1 2 3 4 5 6 7 8 9 10

On the four body diagrams to the right, please mark all painful areas at this time; feel free to use your own words to describe each painful/affected area, or choose from the list provided:

- Sharp and pin-point
- Deep
- Dull
- Aching
- Cramping
- Cramping/aching
- Gnawing
- Wave-like
- Not localized
- Throbbing
- Burning
- Pulsating
- Sharp
- Lancinating
- Shocking
- Pounding
- Tingling
- Continuous
- Intermittent



Please list any and all daily, work or recreational activities, as well as any specific movements or positions that make your pain worse, including:

Lying down Sitting Standing Walking Stress Coughing/sneezing/straining

Daily activities:

_____

_____

Work duties:

_____

_____

Recreational activities:

_____

_____

Please list all specific movements or positions that alleviate or lessen your pain:

_____

_____

Please list all previous or current treatment received for your ailment

_____

_____

Is your pain: ☐ getting better ☐ getting worse ☐ staying the same

If you reported low back pain, please refer to Appendix A and answer all questions accordingly.

If you reported abdominal pain, please refer to Appendix B and answer all questions accordingly.

Are you currently experiencing any of the following? Please circle those that apply:

Fatigue	Weight loss/gain (unintentional)	Numbness
Malaise	Nausea/vomiting	Weakness
Fever	Dizziness/lightheadedness/falls	Change in cognition/mentation

Regarding your mental/psychological well-being, please answer the following 3 questions:

1. In the past month, have you often been bothered by feeling down, depressed, or hopeless? ☐ Yes ☐ No
2. In the past month, have you often been bothered by little interest or pleasure in doing things? ☐ Yes ☐ No
3. Is this something with which you would like help? ☐ Yes ☐ No

Past Medical History

Please circle all that apply. *If you circle 1, 2 or 3, please fill out Appendix C. If you circle 5, 6, 7, 8 or 9, please fill out Appendix E*

1. Heart disease
2. Chest pain
3. Respiratory disease
4. High blood pressure
5. Diabetes
6. Hyperthyroid
7. Hypothyroid
8. Osteoporosis
9. Metabolic Disorders
10. Rheumatoid Arthritis
11. Other connective tissue disease
12. Stroke/TIA
13. Fibromyalgia
14. Blood Clots
15. Lung Cancer
16. Breast Cancer
17. Prostate Cancer
18. Colon Cancer
19. Skin Cancer
20. Bone Cancer
21. Leukemia
22. Lymphoma
23. Other Cancer: _____
24. Pregnant (Appendix D)
25. Previous pregnancy (Appendix D)
26. Recent Infection _____
27. Asthma
28. Chemical Dependency
29. COPD
30. Epilepsy/seizures
31. Headaches
32. Anemia
33. Epilepsy/seizures
34. Emphysema
35. Kidney Disease
36. Liver Disease
37. Osteoarthritis

Please list previous surgeries/dates:

General: _____

_____

Orthopedic: _____

_____

Other: _____

_____

Please list any diagnostic tests:

Radiographs (X-Rays) _____

CT Scan _____

MRI _____

EMG/NCV Nerve Studies _____

Injections _____

Other: _____

_____

Describe your regular exercise routine: _____

_____

_____

Do you smoke? ☐ Yes ☐ No

If yes, how many packs/day? _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how many drinks/day/week? _____

If you are pregnant or post-partum, fill out Appendix D

Office use only: Functional Scales Scores

Neck Index: _____

Quick Dash: _____

Oswestry: _____

Harris Hip: _____

LEFS: _____

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Medication Record

Please list all current medications, including anti-inflammatory (steroids, NSAID's), pain, cholesterol, blood pressure, mental health, cardiac, respiratory, gastrointestinal medicines and over the counter supplements.

	MEDICATION	DOSAGE	FREQUENCY
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			

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Appendix A: Lower Back Pain

1. Have you experienced recent trauma? ☐ Yes ☐ No
2. Have you been diagnosed with osteoporosis? ☐ Yes ☐ No
3. History of cancer? ☐ Yes ☐ No
4. History of abdominal aortic aneurysm? ☐ Yes ☐ No
5. Recent infection? ☐ Yes ☐ No
6. Recent fever/chills/night sweats? ☐ Yes ☐ No
7. Recent unexplained weight loss? ☐ Yes ☐ No
8. Have you been on prolonged steroid use? ☐ Yes ☐ No
9. Are you and IV drug user? ☐ Yes ☐ No
10. Have you had recent transplant surgery? ☐ Yes ☐ No
11. Do you have night pain unrelated to movement? ☐ Yes ☐ No
12. Have you experienced a recent numbness in your groin, perianal, labium or testicles? ☐ Yes ☐ No
13. Have you experienced recent bowel or bladder dysfunction, including urinary retention, changes infrequency, incontinence, pain with urination? ☐ Yes ☐ No
14. Have you experienced a recent increase in numbness/tingling, and or a decrease in leg strength? ☐ Yes ☐ No

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Appendix B: Abdominal Pain

Cluster 1

1. Does coughing, sneezing, or taking a deep breath make your pain worse? ☐ Yes ☐ No
2. Do activities such as bending, sitting, lifting, twisting, or turning over in bed make your pain worse? ☐ Yes ☐ No
3. Has there been any change in your bowel habit since the start of your symptoms? ☐ Yes ☐ No

Cluster 2

1. Does eating certain foods make your pain worse? ☐ Yes ☐ No
2. Has your weight changed since your symptoms started? ☐ Yes ☐ No

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Appendix C

Regular physical activity is fun and healthy. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are between the ages of 15 and 69 and planning to become much more physically active than you are now, answer the seven questions in the box below. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

☐ Yes ☐ No	1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
☐ Yes ☐ No	2. Do you feel pain in your chest when you do physical activity?
☐ Yes ☐ No	3. In the past month, have you had chest pain when you were not doing physical activity?
☐ Yes ☐ No	4. Do you lose your balance because of dizziness or do you ever lose consciousness?
☐ Yes ☐ No	5. Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?
☐ Yes ☐ No	6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
☐ Yes ☐ No	7. Do you know of any other reason why you should not do physical activity?

If you answered YES to one or more questions...

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about which questions you answered YES.

- You may be able to do any activity you want — as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

PLEASE NOTE: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional.

Ask whether you should change your physical activity plan.

If you answered NO to all questions...

If you answered no honestly, you can be reasonably sure that you can:

- start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

Delay becoming much more active:

- if you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better.
- if you are or may be pregnant – talk to your doctor before you start becoming more active.

Name _____

Signature _____ Signature of parent _____

Date _____

Witness _____

Powhatan Physical Therapy assumes no liability for persons who undertake physical activity, and, if in doubt after completing this questionnaire, consult your doctor prior to physical activity.

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Appendix D: Pregnancy or Post-Partum

Pregnancy

1. Complications for present pregnancy?

_____

2. Complications with prior pregnancy?

_____

3. Did your present musculoskeletal symptoms exist before pregnancy or with prior pregnancies? ☐ Yes ☐ No

4. Presently experiencing urinary or anal incontinence? ☐ Yes ☐ No

5. Medications presently taking and what was stopped due to pregnancy?

_____

_____

_____

Post-Partum

1. Bed rest during pregnancy? ☐ Yes ☐ No

2. Type of delivery: ☐ Caesarean ☐ Vaginal

3. Complications? _____

_____

_____

_____

4. Episiotomy or tears in perineum? ☐ Yes ☐ No

5. Forceps or vacuum extraction? ☐ Yes ☐ No

6. Incontinence? ☐ Yes ☐ No

7. Current symptoms present during or prior to pregnancy? _____

_____

_____

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Appendix E

1. Have you ever had head/neck radiation or cranial/head surgery? ☐ Yes ☐ No
2. Have you ever had a head injury? ☐ Yes ☐ No
3. Have you been diagnosed with diabetes, or "sugar" in your blood? ☐ Yes ☐ No
4. Any changes in vision, such as blurred vision, double vision, loss of peripheral vision, or sensitivity to light? ☐ Yes ☐ No
5. Have you had an increase in your thirst or number of times you need to urinate? ☐ Yes ☐ No
6. Increase in appetite? ☐ Yes ☐ No
7. Do you bruise easily? ☐ Yes ☐ No
8. Do cuts/injuries heal slowly? ☐ Yes ☐ No
9. Decrease in muscle strength? ☐ Yes ☐ No
10. Muscle cramping or twitching? ☐ Yes ☐ No
11. Unexplained fatigue? ☐ Yes ☐ No
12. Increase in collar size, difficulty breathing or swallowing? ☐ Yes ☐ No
13. Any changes in skin color? ☐ Yes ☐ No
14. Have you been told you have osteoporosis, or brittle bones? ☐ Yes ☐ No
15. Cushing's Disease/Syndrome? ☐ Yes ☐ No
16. Difficulty going up stairs or getting out of a chair? ☐ Yes ☐ No

If you have been diagnosed with Diabetes:

1. What type of insulin do you take? _____
2. What is your schedule? _____
3. Do you ever have episodes of hypoglycemia or insulin reaction? ☐ Yes ☐ No
4. Do you carry a source of sugar for emergencies? ☐ Yes ☐ No
5. Have you ever had diabetic ketoacidosis? ☐ Yes ☐ No
6. Do you use the finger stick method for determining blood glucose levels? ☐ Yes ☐ No
7. Do you have difficulty maintaining your "numbers"? ☐ Yes ☐ No
8. Do you have any burning, numbness or a loss of sensation in your hands or feet? ☐ Yes ☐ No