PROLIANCE SPORTS THERAPY & REHABILITATION

PROLIANCE SURGEONS, INC. P.S.

MEDICAL INTAKE / PATIENT QUESTIONNAIRE

Name: ____ **Date of Birth:** ____/____/_______

Area of Injury: ____________________________ **Side of body**: L R **Hand Dominance**: L R

Date of Injury: ____________________________ **Date of Surgery:** ____________________________

How did the Injury Occur: ____

Briefly describe your symptoms (what makes it better / worse, what it prohibits you from doing, etc.)

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Have you ever had physical/occupational therapy or other treatment for this problem? (chiropractic, acupuncture, braces/splints, etc.) **If yes, please describe**:

____

____

Relevant operative or invasive procedures and/or injuries:

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Diagnostic Testing: X-Ray CT Scan EMG MRI

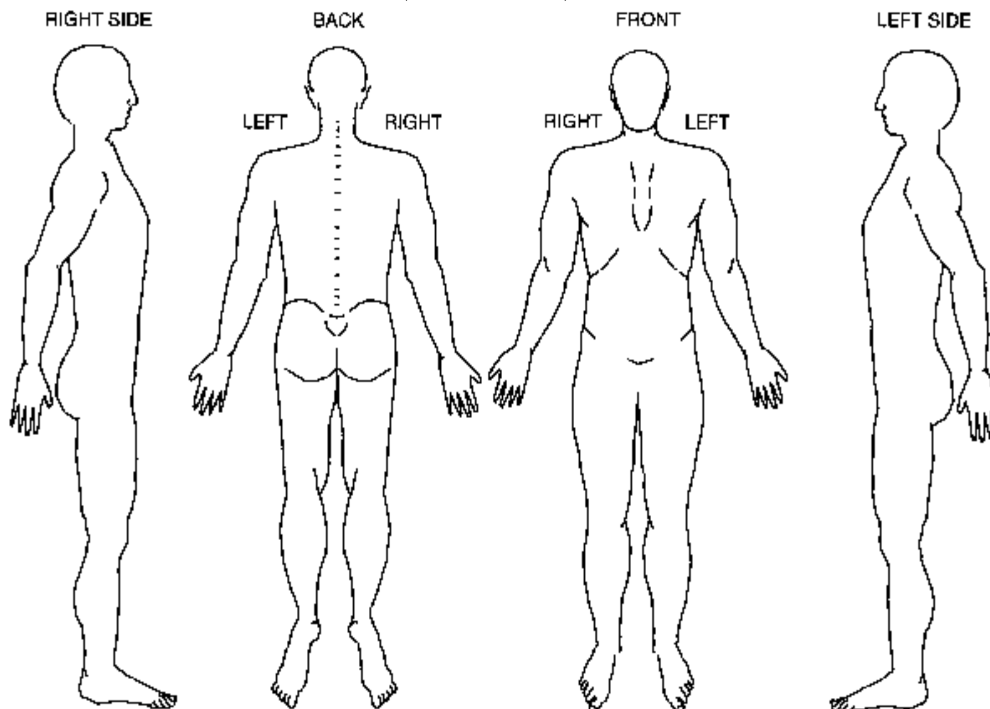
Results (if known): ____

____

Please rate your pain level on a scale from 0 to 10. Circle the appropriate number. Use the diagram to circle any problem areas where you have experienced pain in the last week.

0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

(No Pain) (Moderate Pain) (Severe Pain)



Please indicate if you have, or have ever had, the following conditions:

Heart Disease	Gout	Osteoarthritis
Lung Disease	Neurologic Disorder	Rheumatoid Arthritis
Cancer	Depression	Asthma
High Blood Pressure	Kidney Disease	Osteoporosis
Stroke	Liver Disease	DVT (Blood Clots)
Diabetes	Thyroid Condition	Pacemaker
Seizures	Hepatitis	Other: ________________
Irregular Heart Rate	AIDs/HIV	

Do you have any metal implants or artificial joints?		Yes	No
Are you currently taking steroid medication?		Yes	No
Are you a smoker?		Yes	No
Are you or could you be pregnant?		Yes	No
Are you currently employed?		Yes	No
What is your works status?	Full Duty	Light Duty	Out of Work
	Student	Retired	Disability
	Restrictions	Part Time	Other

What are your job duties/responsibilities? ____

Please list your current medications: ____

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Allergies: ____

What are your personal goals during physical therapy? (e.g., return to work, resume a recreational activity, dress yourself, negotiate stairs, etc.)

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Date of the next physician's visit: ______________________

Patient Signature: ______________________________ Date: ______________

Therapist Signature: ______________________________ Date: ______________