



Sports and Physical Therapy Associates
Medical Questionnaire

Thank you for taking the time to fill out this questionnaire in regards to your current and past medical history. Please answer accurately and completely. The answers you supply will help us to determine the best course of treatment for you. We appreciate your cooperation.

1. Injury/Diagnosis: _____

2. Date of Injury _____ Date of Surgery: _____

3. In regards to your current condition, please indicate the date (if known) of your doctor's visit:
Initial evaluation: _____ Most recent: _____ Next visit: _____

4. Have you had recent diagnostic testing for this injury (i.e. xrays/MRI, CT scan)?
Yes or No Date: _____

If YES, please note which test and results (if known):

5. Are you presently working? Yes or No Has your position been modified? _____

6. Are you currently exercising and/or participating in sports? Yes No
If yes, how often? ___ 1-2x/week ___ 2-3x/week ___ 3-4x/wk ___ 5+x/week

7. Please indicate all of the following conditions that apply, either presently or in the past:

| | |
|---------------------------|---|
| ___ High blood pressure | ___ Chronic obstructive pulmonary disease |
| ___ Gout | ___ Emotional/Psychological |
| ___ Varicose vein | ___ Angina, Heart attack |
| ___ Currently pregnant | ___ Heart surgery, Date _____ |
| ___ Epilepsy/Seizure | ___ Arthritis |
| ___ Stroke | ___ Diabetes |
| ___ Dizziness or fainting | ___ Pace maker |
| ___ Cancer | ___ Allergies, specify _____ |
| ___ Other: _____ | |

8. Please list any prior surgeries you think may affect your treatment program:

9. Are you currently taking medication(s)? _____

If so, please list them below:

Your Name: _____