Name:
DOB:
Age:
Chart: Date:

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**Orthopaedic Surgery Associates**

**OF MARQUETTE PC**

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## Physical Therapy
## Medical/Functional Questionnaire

Date:______________________

Patient Name: ________________________________

Have you EVER been diagnosed as having any of the following conditions?

| | | | | | |
|---|---|---|---|---|---|
| Cancer (kind:___________) | Yes | No | Depression | Yes | No |
| Epilepsy/Seizures | Yes | No | Hepatitis | Yes | No |
| Heart Problems/Pacemaker | Yes | No | Tuberculosis | Yes | No |
| Circulation Problems | Yes | No | Stroke | Yes | No |
| High/Low Blood Pressure | Yes | No | Anemia | Yes | No |
| Emphysema/Bronchitis | Yes | No | Osteoporosis | Yes | No |
| Diabetes | Yes | No | Pregnancy | Yes | No |
| Asthma | Yes | No | Chemical Dependencies | Yes | No |
| Arthritis | Yes | No | Other:________________________________ | | |

Please describe any significant injuries, diseases or conditions you've been treated for (including fractures, dislocations, surgeries and joint replacements) and the approximate dates: ________________________________

________________________________

________________________________

________________________________

________________________________

Do you have any allergies? (medications, foods or environmental) ________________________________

________________________________

Current Medications (including over the counter medications) ________________________________

________________________________

________________________________

________________________________

Describe your injury or problem (including date of onset) ________________________________

________________________________

________________________________

________________________________

Is this a work related problem?________________________________

Diagnostic Tests for current problem (X-Ray, MRI, CT scan, etc.) ________________________________

________________________________

Have you had PT for this problem in the past? If yes, when and where: ________________________________

________________________________

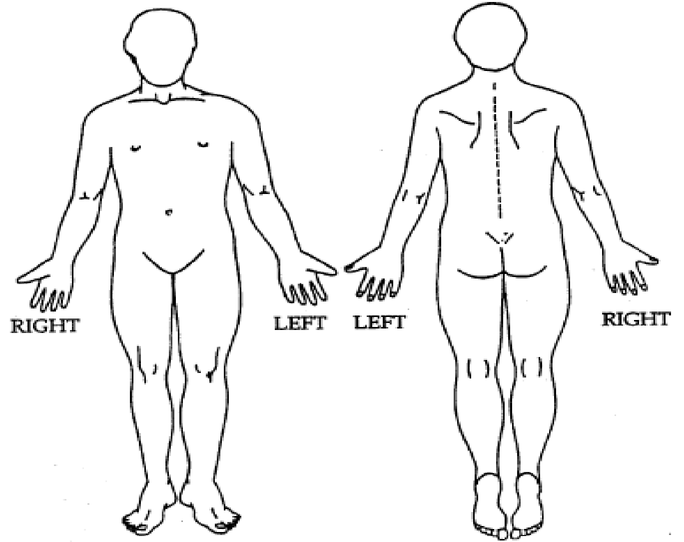
Name:
DOB:
Age:
Chart: Date:

When are you going to see your physician next? ____________________

Rate your CURRENT pain on a scale of 0 to 10, where 0 is no pain and 10 is the worst pain.

0 1 2 3 4 5 6 7 8 9 10

Mark on the diagram where you feel your pain.




Chief Complaints/Describe your symptoms:

____________________
____________________
____________________

Please list any work, home or recreational activities your problem is affecting.

____________________
____________________
____________________
____________________
____________________

Are there any personal goals you would like to accomplish from your time in therapy to improve your ability to do your work, home, personal care, or recreational activities?

____________________
____________________
____________________
____________________

Patient Name: ____________________ Patient Signature: ____________________
Print Name