danica LLC
CENTER FOR PHYSICAL THERAPY
& MOVEMENT INTEGRATION

Medical History / Subjective Questionnaire

Name ___________________________________ **Age** ______ **Date**___________________

How did you hear about danica, LLC? ____

What is the problem that brought you to physical therapy? ___________________________

What are your personal goals for therapy at this time?

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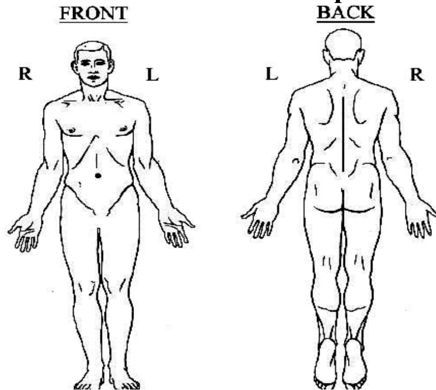
____

How did your pain / problem occur? [ ] Suddenly [ ] Gradually [ ] After Trauma
Please describe: ____

Please circle the number which best represents the average <u>level of pain</u> you have experienced over the last 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Please shade in the area of pain:



When did you first notice the pain or have functional problems due to the condition/injury?
Please provide approximate dates
First Episode:______ Most recent:________

Since the most recent episode, is the pain
[ ] increasing? [ ] decreasing? [ ] not changing?

Is the pain:
[ ] Constant (76-100%)
[ ] Frequent (51-75%)
[ ] Occasional (26-50%)
[ ] Intermittent (25% or le

Currently I am experiencing (circle all that apply):

Fever / Chills / Sweats   Poor Balance / Falls   Unexplained weight loss
Numbness or Tingling   Changes in Appetite   Difficulty swallowing
Depression   Shortness of Breath   Dizziness   Nausea / Vomiting   Headaches
Increased pain at night   Increased pain with cough or sneeze   Changes in bowel or bladder function

Are you a smoker? [ ] Yes [ ] No   Are you pregnant? [ ] Yes [ ] No

Past Medical History: Please circle each condition that you have been told you have (or had):

Cancer   Diabetes   Kidney Disease   Liver Disease   Stroke
High Blood Pressure   Heart Disease   Angina / Chest Pain   Ulcers   Fibromyalgia
Osteoporosis   Osteoarthritis   Rheumatoid Arthritis   Sexually Transmitted Disease
Allergies / Asthma   Lung Disease

Have you had a recent illness? [ ] Yes [ ] No
If yes, explain ____

Past Surgical History (list & date)

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____

List any diagnostic tests that you have had for this condition ________________________

____

Please list all other incidents of trauma, such as car accidents, etc. _____________________

____

____

How would you grade your stress level? [ ] Minimal [ ] Moderate [ ] Greatly Stressed

General physical activity [ ] No exercise [ ] Light [ ] Moderate [ ] Strenuous exercise

____

Are you currently working? [ ] Yes [ ] No **Occupation** _______________________

How many hours per week? ________

Physical Activity at Work [ ] Mainly Sitting [ ] Light [ ] Moderate [ ] Heavy Manual Labor

PRESCRIPTION MEDICATIONS/ SUPPLEMENTS:

_________________________________ _________________________________

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