Smolczynski Physical Therapy
MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Age: _____ Date of Evaluation: _____

Weight: _____ Height: _____ Marital Status: _____ Gender: _____

Referring Physician: _____ Family Physician: _____

Main Problem (how and when pain/symptoms): _____

_____

Other Treatment (P.T., chiropractic, etc.) _____

Date of Last Physical: _____ Allergies: _____

Tests (X-rays, MRI, Bone Scan): _____

List of Medications: _____

Surgeries: _____

Medical Screening

Check (✓) **Yes** or **No**

Have you or any immediate family member been told you have:

	Self		Family	
Cancer	☐ Yes	☐ No	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	☐ Yes	☐ No
Angina/Chest Pain	☐ Yes	☐ No	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	☐ Yes	☐ No
Thyroid condition	☐ Yes	☐ No	☐ Yes	☐ No

Do you have a history of:

Allergies/Asthma	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Rheumatic fever	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No

In the past 3 months, have you had or did you experience:

A change in your health	☐ Yes	☐ No
Fever/chills/sweats	☐ Yes	☐ No
Numbness/tingling	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Urinary tract infection	☐ Yes	☐ No
Nausea/vomiting	☐ Yes	☐ No
Unexplained weight change	☐ Yes	☐ No
Changes in appetite	☐ Yes	☐ No
Changes in bowel function	☐ Yes	☐ No
Changes in bladder function	☐ Yes	☐ No
Upper respiratory infection	☐ Yes	☐ No

Are you currently:

Pregnant	☐ Yes	☐ No
Depressed	☐ Yes	☐ No
Under stress	☐ Yes	☐ No
Have a pacemaker	☐ Yes	☐ No

How are you sleeping at night? (check one)

☐ Fine
☐ Moderate difficulty
☐ Only with medication

Do you or have you smoked tobacco? (check one)

☐ Yes ☐ No

If Yes, # of years _____

Last tobacco use _____

I currently have difficulty with (check all that apply):

☐ Driving
☐ Getting up from a chair
☐ Walking
☐ Bending at the waist

Are your symptoms: (check one)

☐ Getting worse
☐ The same
☐ Getting better

THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE.

Visual Pain Scale

Please rate the severity of your pain by circling a number below:

No Pain	0	1	2	3	4	5	6	7	8	9	10	*Unbearable Pain*

Please indicate the painful areas of your current symptoms:

Instructions:

- Draw each area of your pain or symptoms onto the chart below
- Choose the number and letter from the lists below to describe your symptoms
- Put the date each area of symptom started for this episode to the best of your knowledge

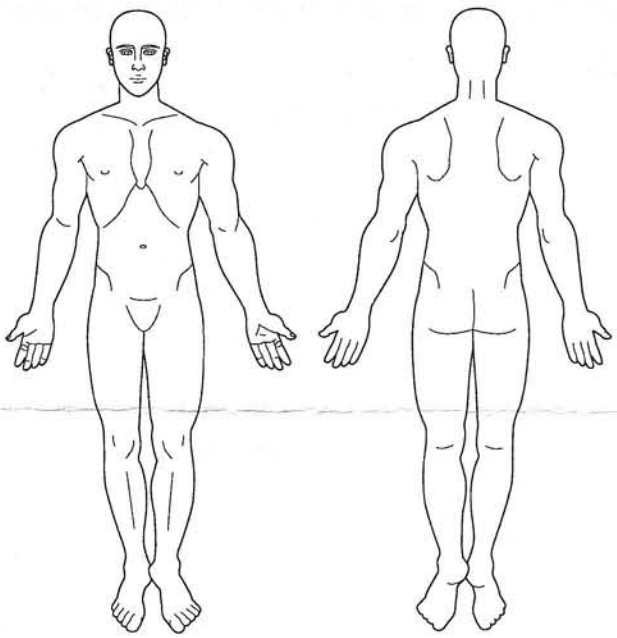
Please note the words that may help describe the symptoms **(use all words that apply)**

1. Sharp
2. Shooting
3. Burning
4. Dull
5. Throbbing
6. Pulling
7. Ache
8. Tingling
9. Numb
10. Heavy
11. Tight
12. Stabbing

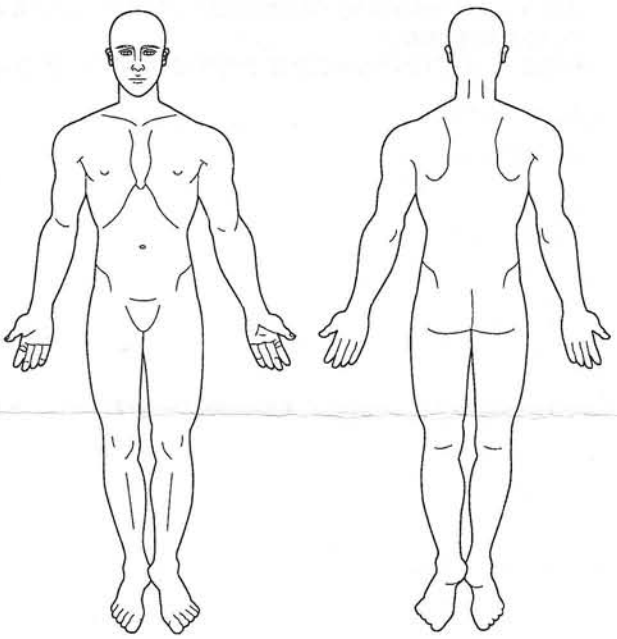
Please note the words that describe your pain

A. Constant (never goes away)
B. Intermittent (relieved with position change or rest)
C. Occasionally (Daily or less frequent)
D. Infrequent (once a week)
E. Variable (comes and goes)

Example:



Please mark the areas of your symptoms:



PATIENT MASTER REGISTRATION SHEET

PATIENT_____ SS#_____
LAST FIRST MIDDLE

ADDRESS _____

CITY_____ STATE_____ ZIP_____ PHONE_____

DATE OF BIRTH_____ AGE_____ SEX_____ REFERRING PHYSICIAN_____

RESPONSIBLE PARTY_____ RELATIONSHIP_____

PRIMARY INSURANCE: (circle one)
MC BC BS AUTO COMMERCIAL COMPENSATION _____

POLICY # _____ GROUP # _____ NAME OF POLICYHOLDER _____

SECONDARY INSURANCE: (circle one)
MC BC BS 65 SPECIAL OTHER_____

POLICY # _____ GROUP # _____ NAME OF POLICYHOLDER _____

MEDICARE: PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST TO PROVIDER AND PHYSICIANS, UNDER TITLE XVIII.

NAME OF BENEFICIARY_____ HEALTH INSURANCE CLAIM # _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to_____ for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.
PATIENT, PATIENT'S AGENT, REPRESENTATIVE OR LEGAL GUARDIAN

SIGNATURE_____ DATE_____ TELEPHONE #_____

☐ **MEDICARE PATIENT'S Authorization to File Secondary Insurance:**
I request that payment of authorized Medigap benefits be made either to me or on my behalf to _____ for any services furnished me by that physician/supplier. I authorize any holder of Medicare information about me to release to _____ any information needed to determine these benefits payable for related services.

SIGNATURE_____ NAME OF 2ND INSURANCE CO._____

☐ **COMMERCIAL INSURANCE, BLUE CROSS OR BLUE SHIELD AUTHORIZATION TO RELEASE INFORMATION:**
I hereby authorize the physician/surgeon to release medical information to my insurance company or employer as required to obtain payment for treatment rendered. I understand that I may cancel this authorization at any time with written notice.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment be made to physician/surgeon under the terms of my insurance policies both with respect to hospital and/or professional services rendered to me.
PATIENT, PATIENT'S AGENT, REPRESENTATIVE OR LEGAL GUARDIAN.

_____
SIGNATURE DATE SSAN TELEPHONE NUMBER

☐ **WORKMAN'S COMPENSATION**
This is a compensation case_____
EMPLOYEE'S SIGNATURE DATE TELEPHONE NUMBER

My Employer is:_____
DATE OF INJURY

Employer's Address_____
STREET CITY STATE ZIP

☐ **SELF PAY PATIENT:**
I do not have insurance coverage and will assume responsibility for the charges.

_____
SIGNATURE DATE TELEPHONE NO SS#

REV. 11/05