SPORTS MEDICINE & PHYSICAL THERAPY

445 St. Paul Street

Tel: (401)-597-5665 North Smithfield, RI 02896 Fax: (401)-597-5667

Patient Name: _____ Date: _____
Date of Birth: _____ Email Address: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: _____ Cell Phone #: _____ Work Phone #:_____
Occupation:_____ Employer: _____
Work Address: _____
City: _____ State: _____ Zip: _____
Emergency Contact Person: _____ Relation to Patient: _____
Emergency Contact #: _____
Primary Care Physician: _____ Referring Physician: _____

MEDICAL HISTORY QUESTIONNAIRE: Circle one. If yes, please explain:

YES NO Do you have high blood pressure?
YES NO Do you smoke?
YES NO Do you have any history of heart problems/surgery?
YES NO Do you have a pacemaker?
YES NO Do you experience chest pain with exertion?
YES NO Do you have a problem with shortness of breath?
YES NO Do you have asthma, bronchitis, or emphysema?
YES NO Do you have a history of stroke/TIA?
YES NO Do you have any allergies (please include allergies to latex)?
YES NO Do you have heartburn, stomach, or intestinal upset?
YES NO Do you have a history of depression?
YES NO Have you experienced recent weight loss or gain?
YES NO Have you experienced recent loss of appetite?
YES NO Have you experienced night sweats or fever?
YES NO Do you have pain at night that interrupts your sleep?
YES NO Do you have any bowel and/or bladder problems?
YES NO Do you have any thyroid problems?
YES NO Do you have diabetes?
YES NO Do you or have you had any cancer/chemotherapy/radiation?
YES NO Do you have a history of infectious disease?
YES NO Do you have arthritis?
YES NO Do you have osteoporosis?
YES NO Do you have severe or frequent headaches?
YES NO Do you have frequent joint sprains/muscle strains?
YES NO Do you have a history of fractures?
YES NO Do you have any pins or metal implants?
YES NO Have you ever had a head injury?
YES NO Do you have a history of neck/back pain?
YES NO Are your hands or feet usually cold?
YES NO Do your arm, hands, legs, or feet swell?

YES NO Do you fatigue easily?
YES NO Do you have any numbness or tingling?
YES NO Do you have any weakness in your arms or legs?
YES NO Do you have difficulty with balance or coordination?
YES NO Do you experience dizziness or fainting?
YES NO Do you have vision or hearing difficulty?

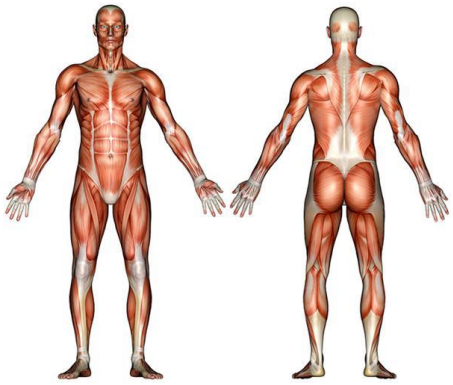
For Women Only:

YES NO Are you pregnant?
YES NO Are you having your menstrual period?
YES NO Do you have a history of abnormal menstrual cycles?

Please rate your pain from 1-10 (1 = no pain: 10 = the worst pain you have ever had)

1 5 10

Please Shade Symptomatic Areas:



Medications: (Please list all medications, dosage, and purpose.)

_____

Surgeries/Dates:

_____

Other Medical Problems: (Those not mentioned in questionnaire)

_____

Have you ever had any of the following Medical or Rehabilitative Care for this injury/episode? If yes, when?

□ **Physician**
□ **Chiropractor**
□ **Physical Therapist**
□ **Occupational Therapist**
□ **Massage Therapist**
□ **Orthopedist**
□ **Neurologist**
□ **Podiatrist**
□ **X-Rays**
□ **MRI**
□ **CT Scan**
□ **Bone Scan**
□ **EMG/NCV**
□ **Myelogram**
□ **Blood Chemistry**
□ **Other: _____**

I believe all the information included in this form to be correct to the best of my knowledge:

Patient/Guardian Signature: _____ Date:_____