INDIANA TOTAL THERAPY

REHABILITATION MEDICAL HISTORY QUESTIONNAIRE

NAME_____ DATE OF BIRTH_____ AGE _____ TODAY'S DATE_____

ADDRESS _____ CITY:_____ STATE:_____ ZIP:_____

HOME PHONE _____ CELL _____

WEIGHT_____ HEIGHT_____ MARITAL STATUS: Married Widowed Divorced Single GENDER M / F

REFERRING PHYSICIAN_____ FAMILY PHYSICIAN_____

MAIN PROBLEM (HOW & WHEN PAIN/SYMPTOMS BEGAN)_____

OTHER TREATMENT (PT, CHIROPRACTIC, ETC.)_____

TESTS (X-RAYS, MRI, BONE SCAN)_____

LIST OF MEDICATIONS_____

SURGERIES_____

WORKING: yes / no FT PT Light Duty EMPLOYER: _____ TYPE OF WORK _____

REVIEW OF SYSTEMS / MEDICAL SCREENING

Have you or any immediate family member been told you have: (circle yes or no)

	Self	Family		Self	Family
Cancer	yes no	yes no	Diabetes	yes no	yes no
High Blood Pressure	yes no	yes no	Heart Disease	yes no	yes no
Angina/Chest Pain	yes no	yes no	Stroke	yes no	yes no
Osteoporosis	yes no	yes no	Tuberculosis	yes no	yes no
Arthritis	yes no	yes no	Thyroid Condition	yes no	yes no

Have you had or do you experience:

CONSTITUTIONAL:
Weigh Loss yes no
Fatigue yes no
Fever/Chills/Sweats yes no
Hepatitis yes no
Pregnant yes no
Difficulty Sleeping yes no

EYES:
Glasses / Contacts yes no
Eye Pain yes no
Double Vision yes no
Cataracts yes no

EAR/NOSE/THROAT:
Difficulty Hearing yes no
Ringing in Ears yes no
Vertigo yes no
Sinus Trouble yes no
Nasal Stuffiness yes no
Frequent Sore Throat yes no

CARDIOVASCULAR:
Murmur yes no
Chest Pain yes no
Palpitations yes no
Dizziness yes no
Fainting Spells yes no
Difficulty Lying Flat yes no
Swelling Ankles yes no
Pacemaker/Defibrillator yes no

ENDOCRINE:
Loss of Hair yes no
Heat/Cold Intolerance yes no

RESPIRATORY:
Cough yes no
Coughing Blood yes no
Wheezing yes no
Shortness of Breath yes no
Smoke yes no
Bronchitis yes no
Upper Resp. Infection yes no

GASTROINTESTINAL:
Heartburn/Reflux yes no
Nausea/Vomiting yes no
Constipation yes no
Change in Bowel yes no
Diarrhea yes no
Jaundice/Kidney Disease yes no
Abdominal Pain yes no
Difficulty Swallowing yes no
Change in Appetite yes no

GENITOURINARY:
Burning/Frequency yes no
Night Time Urination yes no
Blood in Urine yes no
Erectile Dysfunction yes no
Abnormal Discharge yes no
Bladder Leakage yes no
Urinary Tract Infection yes no

ALLERGIC/IMMUNOLOGIC:
Hives/Eczema yes no
Allergies yes no
Asthma yes no
Rheumatic Fever yes no
Latex Allergy yes no

HEMATOLOGY/LYMPH:
Easy Bruising yes no
Gums Bleed Easily yes no
Enlarged Glands yes no

MUSCULOSKELETAL:
Joint Pain/Swelling yes no
Stiffness yes no
Muscle Pain yes no
Back Pain yes no

PSYCHIATRIC:
Anxiety/Depression yes no
Mood Swings yes no

INTEGUMENTARY (SKIN):
Rash/Sores/Lesions yes no
Itching/Burning yes no
Ulcers yes no

NEUROLOGICAL:
Loss of Strength yes no
Numbness/Tingling yes no
Headaches yes no
Tremors yes no
Memory Loss yes no
Confusion yes no
Slurred Speech yes no
Seizures yes no

□ Other: _____

I currently have pain /difficulty with: (check all that apply):
□ Driving □ Getting up from a chair □ Walking □ Bending at the waist □ Lifting > 10# □ Reaching overhead □ Reaching behind the back □ Standing
□ Ascending / Descending Stairs □ Kneeling □ Extended computer use □ Household chores □ Concentration □ Sitting □ Self care; bathing, dressing, grooming
□ Eating □ Sports □ Recreational Activities □ Exercise □ Other: _____
Are your symptoms: (check one) □ Getting worse □ The same □ Getting better How do you learn best? (check one) □ Visual □ Verbal

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

Patient Signature_____ **Date**_____ **Provider Signature** _____

Parent / Guardian Signature _____ **Date** _____ **Date** _____

INDIANA TOTAL THERAPY

Visual Pain Scale / Body Diagram

PATIENT NAME_____ DOB _____ TODAY'S DATE _____

Please rate the severity of your pain at <u>worst</u> by circling a number below:

☺ **0 1 2 3 4 5 6 7 8 9 10** ☹

None (No pain)	Mild (Annoying)	Moderate (Uncomfortable)	Severe (Dreadful)	Very Severe (Horrible)	Worst Possible (Unbearable)

Pain at best _____/10 Pain on average throughout the day _____/10

PLEASE INDICATE THE PAINFUL AREAS OF YOUR CURRENT SYMPTOMS

Instructions:

-Circle each area of your pain or symptoms onto the chart below.
-Choose the number and letter from the lists below to describe your symptoms.

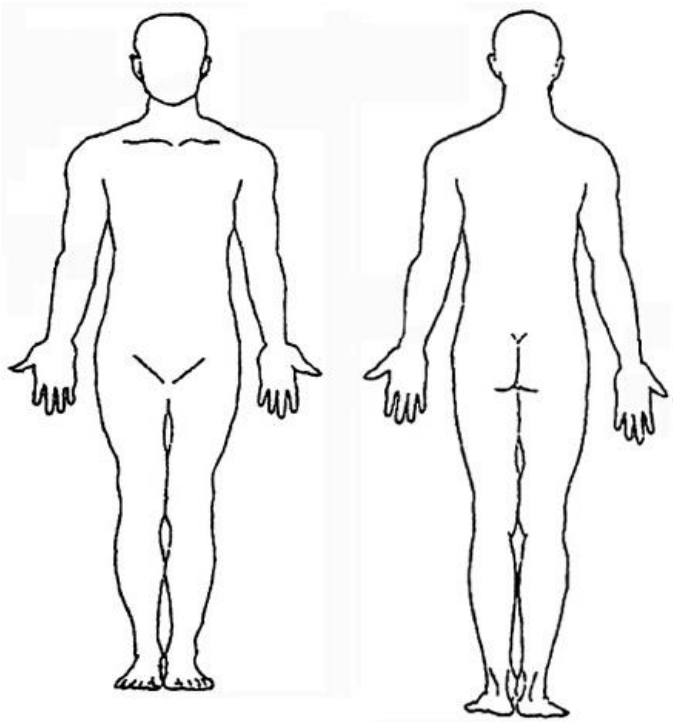
Use all that apply.

1 – sharp	8 – tingling	A – Constant (never goes away)
2 – shooting	9 – numb	B – Intermittent (relieved with position change or rest)
3 – burning	10 – heavy	C – Occasionally (daily or less frequent)
4 – dull	11- tight	D – Infrequent (once a week)
6 – pulling	12 - stabbing	E – Variable (comes and goes)
7 – achy	13 - pinching	

PLEASE MARK THE AREAS OF YOUR SYMPTOMS:

FRONT **BACK**

Right **Left** **Left** **Right**



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

Patient Signature_____ **Date**_____

Parent / Guardian Signature _____ **Date** _____

Provider Signature _____ **Date** _____