Pre-Exam Questionnaire & Medical History

ATHLETICARE
Physical Therapy & Sports Performance

Patient Name:____ Age: _______ ☐ Male ☐ Female

Referring Physician:_____________________________________ Diagnosis:_____________________________

Is this problem related to an injury? ☐ Yes ☐ No If yes, date of injury:____/____/____ Were you injured while working? ☐Yes ☐ No

Have you had surgery? ☐ Yes ☐ No If yes, date of surgery:_____/_____/____ Type of surgery:_______________________

Please list current medications:____
(Or provide List)

Medicare Patients: Have you had any physical and/or speech therapy this calendar year? ☐ Yes ☐ No How many visits? ____________

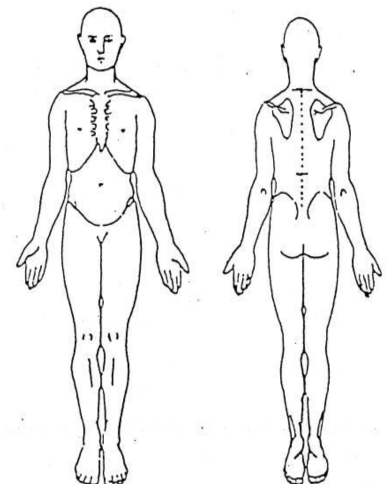
Have you had any at-home care this calendar year? ☐ Yes ☐ No If yes, Date of Discharge (Important):______________

Please check any past or present conditions:

	Yes	No		Yes	No
High Blood Pressure	☐	☐	Neck Injury/Surgery	☐	☐
Low Blood Pressure	☐	☐	Back Injury/Surgery	☐	☐
Heart Disease	☐	☐	Upper Extremity Injury/Surgery	☐	☐
Heart Attack	☐	☐	Lower Extremity Injury/Surgery	☐	☐
Congestive Heart Failure	☐	☐	Osteoarthritis	☐	☐
Blood Clot	☐	☐	Rheumatoid Arthritis	☐	☐
Pacemaker	☐	☐	Weakness	☐	☐
Stroke	☐	☐	Asthma	☐	☐
TIA (Transient Ischemic Attack)	☐	☐	Emphysema	☐	☐
Diabetes	☐	☐	Chronic Bronchitis	☐	☐
Cancer	☐	☐	Shortness of Breath	☐	☐
Gout	☐	☐	Allergies	☐	☐
Epilepsy	☐	☐	Pins or Metal Implants	☐	☐
Fibromyalgia	☐	☐	Hernia	☐	☐
Vision Loss	☐	☐	Osteoporosis	☐	☐
Hearing Loss	☐	☐	Pregnant	☐	☐

Other:____

Please indicate where you currently experience pain. (Be specific)



Please answer the following to the best of your ability:

My pain is: ☐ Constant ☐ Intermittent ☐ Activity Specific ☐ N/A I don't have any pain

Describe your pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Burning ☐ Stabbing ☐ Shooting
☐ Throbbing ☐ Stinging ☐ Cramping ☐ Sore ☐ Numbness
☐ Pins and Needles ☐ Other:_____________________________

Please circle on the scale below the number which best indicates your **CURRENT** level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Emergency Room Pain

Please list any other information that would assist us in your care:_________________________
____

Patient or Parent/Guardian Signature:____ Date:_____________________