ADEPT PHYSICAL THERAPY

7811 Montrose Road Suite 350
Potomac, MD 20854
301-417-8283

MEDICAL QUESTIONNAIRE

Patient Name:	Date of Birth:
Height:	Weight:

DO YOU HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING?

CONDITION	YES	NO	CONDITION	YES	NO
Allergies			Fractures		
Anemia			Hepatitis		
Anxiety			HIV		
Arthritis			Kidney Problems		
Asthma			Metal Implants/Joint Replacement		
Cancer			Multiple Sclerosis		
Cardiac/Heart conditions			Osteoporosis		
Cardiac Pacemaker			Parkinsons		
Chemical Dependency			Rheumatoid Arthritis		
Circulation Problems			Seizures		
Currently Pregnant			Strokes		
Depression			Thyroid Disease		
Diabetes			Tuberculosis		
Dizzy Spells			Vision Problems		
Emphysema/Bronchitis			Are you being threatened or hurt by anyone?		
History of falls in the last 12 months?			Other		

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Describe any other Conditions of Precautions

Current Medications

NAME	DOSAGE

At the present time would you say your health is: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Job Description:

Have you missed work due to your condition/injury?

Last date worked due to this injury | Date returned to work after this injury

Social Activities:

Have you recently noted:

- ☐ Weight loss/gain
- ☐ Nausea/vomiting
- ☐ Dizziness/lightheadedness
- ☐ Fatigue
- ☐ Severe/Frequent headaches
- ☐ Fever/chills/sweats
- ☐ Shortness of breath
- ☐ Bowel or Bladder problems
- ☐ Chest Pain
- ☐ Difficulty Sleeping
- ☐ Weakness
- ☐ Swollen Joints
- ☐ Numbness/Tingling

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Health Habits

How many packs of cigarettes do you smoke a day?
How many days per week do you drink alcohol?

What tests have you had concerning this problem?

X-ray	CT Scan
MRI	EMG
NCV	Other?

To the best of my knowledge, the preceding information is an accurate representation of my pertinent medical history. I understand that if at any time additional information becomes available that may impact my care then I will inform the therapist before continuing treatments. I further authorize the release of any relevant medical information to any medical facility or personnel as necessary to my immediate well-being.

Patient Signature_____ **Date**_____

Therapist's Signature_____ **Date**_____