

**Cornerstone Physical Therapy
Medical History Questionnaire – Minor Patient**

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

School: _____

Do you have a job in addition to going to school? Yes No

If yes, name of Employer/Job Duties: _____

Referring Physician: _____

Date of Onset of Problem/Injury/Surgery: _____

Sports/Recreational Activities/Hobbies: _____

Please provide name of any of the following healthcare professionals you have seen within the last **year**:

Medical Doctor: _____ Psychiatrist/Psychologists: _____

Chiropractor: _____ Occupational Therapist: _____

Dentist: _____ Physical Therapist: _____

OTHER: _____

If you have seen any of the above mentioned **within the last year**, please describe for what reason: _____

Review of Symptoms

Do you currently have any problems in the following areas? If "yes", provide information:

Musculoskeletal	Yes	No	_____
• Muscle Pain	Yes	No	_____
• Joint Pain	Yes	No	_____
• Osteoporosis	Yes	No	_____
Neurological	Yes	No	_____
• Weakness	Yes	No	_____
• Tingling	Yes	No	_____
• Falls	Yes	No	_____
Allergies/Immunologic	Yes	No	_____
• Seasonal Allergies	Yes	No	_____
• Hay Fever Symptoms	Yes	No	_____
Psychiatric	Yes	No	_____
Anxiety	Yes	No	_____
Depression	Yes	No	_____
Tuberculosis	Yes	No	_____

Are you pregnant? Yes No Due Date (if yes): _____

Do you smoke/use chewing tobacco? Yes No If yes, packs per day? _____

Alcohol Consumption (please circle): Never Rarely Socially Often

Please list ANY surgeries or other conditions you have been treated or hospitalized for. Please provide the approximate date and reason for each surgery/hospitalization.

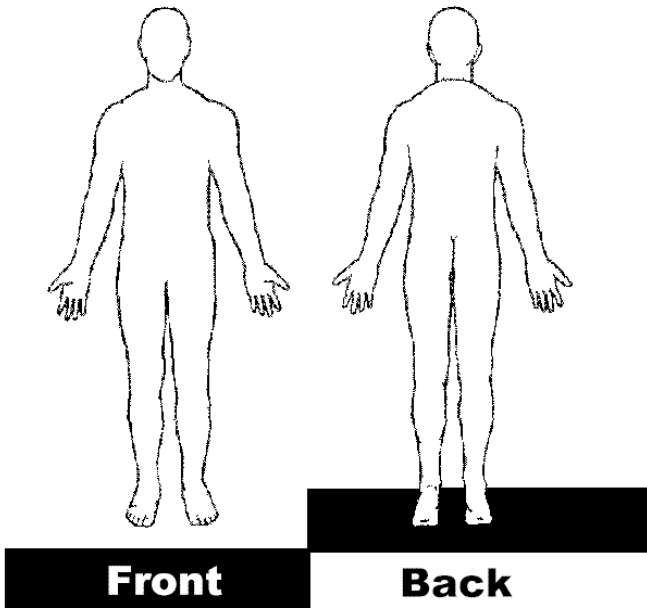
Date	Surgery/Hospitalization	Reason
_____	_____	_____
_____	_____	_____

Check any **OVER-THE-COUNTER** medications you have taken within the last month?

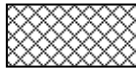


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|-------------------------------------------------------|----------------------------------------|--------------------------------------------------|------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Tylenol | <input type="checkbox"/> Advil/Motrin | <input type="checkbox"/> Ibuprofen |
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> Decongestants | <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Antacid |
| <input type="checkbox"/> Vitamins/Mineral Supplements | | <input type="checkbox"/> Glucosamine/Chondroitin | |

Please list the **PRESCRIPTION** medications you are currently taking and the dosage if known:

Medication	Dosage
_____	_____
_____	_____
_____	_____



Please mark the diagram with your symptoms in the appropriate location:

-  Pain
-  Numbness
-  Tingling, Asleep, Abnormal

Please rate your pain level on a scale of 0-10 (0 being NO pain and 10 being worst):

Please list any additional information that would assist us with your care: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____