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: ______________

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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?

- ☐ Aspirin
- ☐ Tylenol
- ☐ Advil/Motrin
- ☐ Ibuprofen
- ☐ Laxatives
- ☐ Decongestants
- ☐ Antihistamines
- ☐ Antacid
- ☐ Vitamins/Mineral Supplements
- ☐ Glucosamine/Chondroitin

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

Medication	Dosage

Front

Back

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: ____________________________________

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Patient Signature: ____ Date: ____________________

Parent/Guardian Signature: ____ Date: ____________________