MEDICAL HISTORY QUESTIONNAIRE

Please print and complete this questionnaire prior to your first physical therapy appointment. The purpose of this questionnaire is to help us understand your health status. Please complete this form to the best of your ability; your therapist will answer any questions during your exam. This form is considered part of your medical record.

PATIENT **DATE OF BIRTH** **TODAY'S DATE**

GUARDIAN (IF DIFFERENT THAN PATIENT) **RELATIONSHIP TO PATIENT**

ADDRESS **CITY, STATE, ZIP**

BEST PHONE FOR REMINDERS/VOICEMAIL **EMAIL**

EMERGENCY CONTACT NAME AND NUMBER

HOW DID YOU HEAR ABOUT IFAST PT?
PLEASE BE SPECIFIC; WE LOVE TO SEND THANK YOU NOTES

PRIMARY PHYSICIAN AND PHONE NUMBER

ARE YOU ALLERGIC TO LATEX? ☐ **NO** ☐ **YES** ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ NO ☐ YES (PLEASE LIST BELOW)

LIST ALL ALERGIES: _____

REASON FOR VISIT: _____

ONSET DATE OF SYMPTOMS: _____ ONSET OF SYMPTOMS: ☐ GRADUAL ☐ SUDDEN ☐ TRAUMA ☐ ACCIDENT

THIS INJURY INVOLVES: ☐ ATTORNEY ☐ WORKER'S COMPENSATION ☐ DISABILITY ☐ NONE LISTED

SOCIAL HISTORY

ARE YOU PRESENTLY WORKING? ☐ YES ☐ NO IF NO, LIST LAST DATE WORKED. _____

OCCUPATION AND PHYSICAL REQUIREMENTS: _____

LIVING SITUATION: ☐ ALONE ☐ SPOUSE/SIGNIFICANT OTHER ☐ FAMILY MEMBER ☐ FRIEND/ROOMMATE

LIST CURRENT ACTIVITIES (E.G., SPORTS, HOBBIES): _____

DESCRIBE EXERCISE OUTSIDE OF NORMAL DAILY ACTIVITY: _____

317-578-0998 ● OFFICE@IFASTPT.COM ● 9402 UPTOWN DRIVE, SUITE 1600, INDIANAPOLIS, IN 46256

INJURY HISTORY

BRIEFLY DESCRIBE HOW INJURY OCCURRED: _____

_____

MARK ANY SYMPTOMS YOU ARE EXPERIENCING:

☐ PAIN ☐ GRINDING ☐ BRUISING ☐ CRAMPING

☐ SWELLING ☐ CLICKING ☐ STIFFNESS ☐ THROBBING

☐ WEAKNESS ☐ NUMBNESS ☐ LOCKING ☐ BURNING

☐ POPPING ☐ TINGLING ☐ GIVING WAY ☐ SHOOTING

☐ OTHER, PLEASE DESCRIBE: _____

DO YOUR SYMPTOMS CHANGE IN RELATION TO THE TIME OF DAY? ☐ WORSE IN MORNING ☐ WORSE AT NIGHT ☐ NO PATTERN

WHAT FACTORS MAKE YOUR SYMPTOMS WORSE? _____

WHAT FACTORS MAKE YOUR SYMPTOMS BETTER? _____

WHAT TYPES OF TREATMENTS, IF ANY, HAVE YOU HAD FOR THIS PROBLEM?

☐ MEDICATION ☐ CHIROPRACTIC ☐ SURGERY ☐ INJECTION

☐ PHYSICAL THERAPY ☐ SPLINT/BRACE ☐ OTHER: _____

ARE YOU CURRENTLY RECEIVING TREATMENT FOR THE SAME PROCEDURE ELSEWHERE? ☐ YES ☐ NO

WHAT TYPES OF DIAGNOSTIC TESTS, IF ANY, HAVE YOU HAD FOR THIS PROBLEM?

☐ X-RAY ☐ CT SCAN ☐ EMG

☐ MRI ☐ BONE SCAN ☐ OTHER: _____

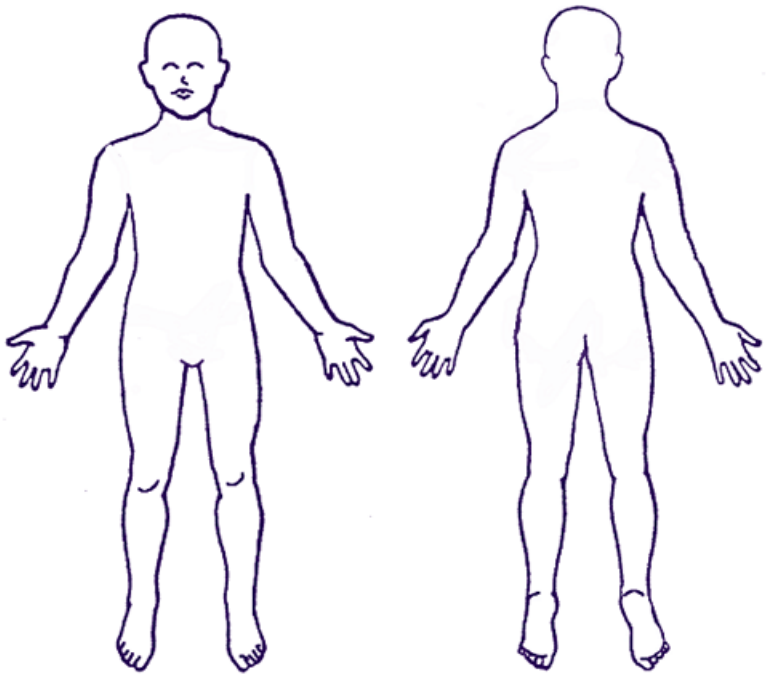
HAVE YOU HAD THESE SYMPTOMS IN THE PAST? ☐ NO ☐ YES. IF YES, PLEASE DESCRIBE HOW IT WAS TREATED:

_____

(Continued on Next Page)

317-578-0998 ● OFFICE@IFASTPT.COM ● 9402 UPTOWN DRIVE, SUITE 1600, INDIANAPOLIS, IN 46256

USING THE BODY DIAGRAM BELOW, PLEASE MARK THE AREAS WHERE YOU ARE CURRENTLY EXPERIENCING SYMPTOMS:



MEDICAL HISTORY

PLEASE INDICATE IF YOU CURRENTLY HAVE, OR HAVE PREVIOUSLY HAD, ANY OF THE FOLLOWING SYMPTOMS:

NOW	PAST	SYMPTOM	NOW	PAST	SYMPTOM	NOW	PAST	SYMPTOM
☐	☐	ALLERGIES	☐	☐	GOUT	☐	☐	PARKINSON'S DISEASE
☐	☐	ANEMIA	☐	☐	GULLIAN-BARRE	☐	☐	PNEUMONIA
☐	☐	ASTHMA	☐	☐	HEADACHES	☐	☐	POLIO
☐	☐	ARTHRITIS	☐	☐	HEART DISEASE	☐	☐	RHEUMATIC / SCARLET FEVER
☐	☐	ANGINA / CHEST PAIN	☐	☐	HEMOPHILIA	☐	☐	STROKE OR TIA
☐	☐	CANCER	☐	☐	HEPATITIS	☐	☐	TUBERCULOSIS
☐	☐	CHEMICAL DEPENDENCY	☐	☐	HIGH/LOW BLOOD PRESSURE	☐	☐	THYROID PROBLEMS
☐	☐	DEPRESSION / ANXIETY	☐	☐	HYPOGLYCEMIA	☐	☐	ULCERS
☐	☐	DIABETES	☐	☐	KIDNEY DISEASE	☐	☐	UNEXPLAINED WEAKNESS
☐	☐	EMPHYSEMA	☐	☐	LIVER DISEASE	☐	☐	HIV / AIDS
☐	☐	EPILEPSY/ SEIZURES	☐	☐	MULTIPLE SCLEROSIS	☐	☐	VISION DIFFICULTY
☐	☐	FIBROMYALGIA	☐	☐	MYOFASCIAL PAIN SYNDROME	☐	☐	HEARING DIFFICULTY
☐	☐	FRACTURES	☐	☐	PACEMAKER	☐	☐	OTHER: _____

317-578-0998 ● OFFICE@IFASTPT.COM ● 9402 UPTOWN DRIVE, SUITE 1600, INDIANAPOLIS, IN 46256

DO YOU WEAR GLASSES OR CONTACTS? ☐ NO ☐ YES. LIST PRESCRIPTION BELOW, IF KNOWN

	SPHERE	CYLINDER	AXIS	PRISM	ADD
RIGHT EYE					
LEFT EYE					

DID/DO YOU WEAR BRACES ON YOUR TEETH AT ANY TIME? ☐ NO ☐ YES. LIST WHAT AND WHEN: _____

DID/DO YOU WEAR ANY OTHER ORAL APPLIANCES? ☐ NO ☐ YES. LIST WHAT AND WHEN: _____

DID/DO YOU WEAR ORTHOTICS IN YOUR SHOES? ☐ NO ☐ YES. LIST WHEN: _____

LIST ANY MEDICATIONS TAKEN IN LAST 6 MONTHS: _____

PREVIOUS SURGERIES: _____

PREVIOUS HOSPITALIZATIONS: _____

PLEASE INDICATE QUANTITY AND FREQUENCY OF CURRENT USE:

CAFFEINE _____ ALCOHOL _____

TOBACCO _____ RECREATIONAL DRUGS _____

PLEASE INDICATE IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING OVER THE LAST YEAR:

☐ FEVER ☐ UNEXPLAINED WEIGHT LOSS OR GAIN ☐ BLOODY OR BLACK STOOLS ☐ LOSS OF BALANCE OR FALLS

☐ EXCESSIVE SWEATING ☐ CHEST PAIN ☐ RASHES

☐ VOMITING ☐ PALPITATIONS ☐ NUMBNESS OR TINGLING

☐ DIARRHEA ☐ CONSTIPATION ☐ PREGNANCY

PLEASE INDICATE ANY OTHER MEDICAL CONDITIONS OR CONCERNS:

_____

PLEASE DESCRIBE YOUR THERAPY GOALS (WHAT YOU WANT TO ACHIEVE DURING THE COURSE OF TREATMENT):

_____

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

317-578-0998 ● OFFICE@IFASTPT.COM ● 9402 UPTOWN DRIVE, SUITE 1600, INDIANAPOLIS, IN 46256

- CONSENT FOR CARE & TREATMENT -

I, the undersigned, do hereby agree and give my consent for IFAST Physical Therapy to furnish medical care and treatment that is considered necessary and proper in diagnosing or treating the patient's physical and mental condition. **INTIAL & DATE** _____

- AUTHORIZATION BENEFIT ASSIGNMENT - FINANCIAL RESPONSIBILITY - RELEASE OF INFORMATION -

I understand that my insurance benefits may not cover charges and that I am responsible for those charges. I understand and agree that I am responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees. By my signature, I authorize IFAST Physical Therapy LLC to release all information necessary, including medical records, to secure payment. A photocopy of this authorization is to be considered as valid as the original. **INTIAL & DATE** _____

- CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION -

I have had full opportunity to read the IFAST Physical Therapy LLC Notice of Privacy Practices. I understand that by signing this consent, I am giving my consent to IFAST Physical Therapy LLC to use and disclose my protected health information to carry out treatment, payment activities and health care operations. I understand the terms of this notice may change with time and IFAST Physical Therapy LLC will always post the current notice at the clinic, on the website or have copies available for distribution. **INTIAL & DATE** _____

Indicated below are individuals whom IFAST Physical Therapy LLC may speak to regarding my treatment.

NAME	RELATIONSHIP TO PATIENT	NAME	RELATIONSHIP TO PATIENT

- SIGNATURE for CONSENT -

By my signature below I acknowledge that I have read, understand and agree to the terms and conditions contained in the Consent for Care and Treatment, the Authorization to release all information necessary to secure payment and the Consent For Use and Disclosure of Health Information.

SIGNATURE (PATIENT OR GUARDIAN)	NAME (PRINTED)	DATE

- PATIENT CONSENT FORM – HIPAA -

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by submitting your request in writing to IFAST Physical Therapy LLC or by reviewing the current copy in our waiting room binder.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

SIGNATURE	NAME (PRINTED)	DATE

OPTIONAL: Please restrict access to my personal health information (PHI) from:

NAME	ADDRESS	PHONE

317-578-0998 ● OFFICE@IFASTPT.COM ● 9402 UPTOWN DRIVE, SUITE 1600, INDIANAPOLIS, IN 46256