Triumph Physical Therapy
8350 Richardson Rd
Commerce Township, MI 48382
947-800-7117 phone
947-800-7109 fax

PATIENT MEDICAL HISTORY & INTAKE QUESTIONNAIRE

Name: _____ DOB: _____

What problem(s) are you being treated for today? (Describe type and location of symptoms)

_____

_____

What date did your present symptoms begin? _____

How did your problem(s) begin: _____

My symptoms are currently: GETTING BETTER GETTING WORSE STAYING THE SAME

My symptoms currently: COME AND GO ARE CONSTANT CONSTANT, BUT CHANGE WITH ACTIVITY

What makes your symptoms better? _____

What makes your symptoms worse? _____

What time of day are your symptoms worse? Morning Afternoon Evening Overnight

Treatment received so far for this problem (please circle): Physical/Occupational Therapy Injections Massage Chiropractic Acupuncture Other: _____

Have you received physical/occupational therapy with the last calendar year? YES ___ NO ___

Approximately how many treatment sessions have you received this calendar year? _____

Indicate special tests performed for this problem and results if known (circle all that apply):

X-ray _____ Bone Scan _____ CT scan _____ MRI _____

Other: _____

What is your goal for therapy? _____

Date of next physician appointment: _____

MEDICAL HISTORY

Have you recently noted any of the following (circle all that apply):

Allergies	Anemia	Anxiety	Arthritis	Asthma
Autoimmune	Cancer	Cardiac	Chemical Dependency	
Circulation	Pregnant	Depression	Diabetes	Dizzy Spells
Emphysema	Fibromyalgia	Fractures	Gallbladder	Headaches
Hearing impairment	Hepatitis	High Cholesterol	High/Low BP	HIV/AIDS
Incontinence	Kidney	Metal Implants	MRSA	Pacemaker
Multiple Sclerosis	Muscular	Osteoporosis	Parkinson's	Rheumatoid Arthritis
Seizures	Smoking	Speech Problems	Strokes	Thyroid
Tuberculosis	Vision Problems			

If yes to any of the above, please explain/Describe any other conditions not listed:_____
_____

Please list past medical history (falls, pacemaker, surgeries, etc.) including dates (indicate if for current condition):_____
_____

During the past month, have you been feeling down, depressed, or feeling sense of hopeless? YES NO

During the past month, have you experienced little interest or pleasure in doing things? YES NO

SOCIAL HISTORY

Home: Please circle choice that applies:
House Condo/Apartment Group Residence Nursing Home

Do you live alone? YES ____ NO ____

Occupation: Are you currently working? Light duty Full Duty Not Working
If not working, date last worked_____
Leisure activities/Hobbies/Exercise Routine: _____
_____

What activities compromise your day? (Circle all that apply): Sitting Standing Walking Lifting
Other:_____

Do you use tobacco? YES___ NO___ if yes, indicate type, amount, and frequency:_____
Alcohol intake and frequency: _____

Is there anything else we should know that is pertinent to your treatment? _____

_____

The above information I have supplied is complete, true, and correct to the best of my knowledge.

Patient/Guardian Signature _____ Date _____