A-TEAM
PHYSICAL THERAPY

MEDICAL INTAKE QUESTIONAIRE

Name: _____ **Date:** _____

Date of Surgery/Accident: _____ **Age:** _____

1.	History of Heart problems	YES / NO	details: _____
2.	Pace-Maker	YES / NO	details: _____
3.	High Blood Pressure	YES / NO	details: _____
4.	Cancer	YES / NO	details: _____
5.	Tumors or cysts removed	YES / NO	details: _____
6.	Tuberculosis	YES / NO	details: _____
7.	Skin Disorders	YES / NO	details: _____
8.	HIV Positive	YES / NO	details: _____
9.	Lung Disease	YES / NO	details: _____
10.	Asthma	YES / NO	details: _____
11.	Are You currently pregnant	YES / NO	details: _____
12.	Headaches	YES / NO	details: _____
13.	Dizziness	YES / NO	details: _____
14.	Blurred vision	YES / NO	details: _____
15.	Vomiting or Nausea	YES / NO	details: _____
16.	Numbness	YES / NO	details: _____
17.	Arthritis	YES / NO	details: _____
18.	Osteoporosis	YES / NO	details: _____
19.	Internal implants (metal or plastic)	YES / NO	details: _____
20.	Diabetes	YES / NO	details: _____
21.	Hepatitis A /B/C	YES / NO	details: _____
22.	Circulation problems	YES / NO	details: _____
23.	Sensitivity to heat or ice packs	YES / NO	details: _____
24.	Other_____		

25. Current Medications: _____

26. Occupation: _____ **Currently Working:** ☐ **YES** ☐ **NO** ☐ **Light Duty**

27. Circle a percentage you feel you are functioning at due to this injury:
(0% = severely restricted and 100% = no restrictions)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

28. Circle a number you feel your pain is: (0 = no pain and 10 = emergency room pain)

At Best: 0 1 2 3 4 5 6 7 8 9 10

At Worst: 0 1 2 3 4 5 6 7 8 9 10