MOBILIZE PHYSICAL THERAPY PATIENT QUESTIONNAIRE

Name:_____Date:_____
Last First MI

Primary Care Physician:_____ Referring Physician:_____

Emergency Contact:_____Relationship:_____

Emergency Contact Phone Number:_____

How did you hear about us?_____

What are your symptoms?_____

_____

How did your injury occur?_____

_____

Is this a work injury? (If yes, please answer the following)_____
Claim Number:_____Adjuster Name and Phone Number:_____

When did your symptoms begin?_____

Have you been diagnosed with any of the following conditions?

☐Allergies	☐Dizzy Spells	☐MRSA
☐Anemia	☐Emphysema/Bronchitis	☐Multiple Sclerosis
☐Anxiety	☐Fibromyalgia	☐Muscular Disease
☐Arthritis	☐Fractures	☐Osteoporosis
☐Asthma	☐Gallbladder Problems	☐Parkinsons
☐Autoimmune Disorder	☐Headaches	☐Rheumatoid Arthritis
☐Cancer	☐Hearing Impairment	☐Seizures
☐Cardiac Conditions	☐Hepatitis	☐Smoking
☐Cardiac Pacemaker	☐High Cholesterol	☐Speech Problems
☐Chemical Dependency	☐High/Low Blood Pressure	☐Strokes
☐Circulation Problems	☐HIV/AIDS	☐Thyroid Disease
☐Currently Pregnant	☐Incontinence	☐Tuberculosis
☐Depression	☐Kidney Problems	☐Vision Problems
☐Diabetes	☐Metal Implants	

If "Yes" to Any of the above, please explain and give approximate dates. Describe any other Conditions: _____

_____

MOBILIZE PHYSICAL THERAPY PATIENT QUESTIONNAIRE

Surgical History Date

_____

_____

Current Medications

_____

_____

Are you seeing any other healthcare providers for this condition?

_____

_____

Have you had previous treatment for this condition?_____

_____

Have you had any of the following tests related to this condition?

☐X-rays ☐MRI ☐Nerve Conduction Study

☐CT Scan ☐Bone Scan ☐EMG

☐Other_____

Results:_____

Since the onset of your symptoms have you had:

☐Difficulty with bowel or bladder functional ☐Fever/Chills ☐Unexplained weight change

☐Dizziness or fainting ☐Weakness ☐Problems with vision/hearing

☐Numbness in genital or anal area ☐Numbness ☐Night pain/sweats

☐Vague feeling of bodily discomfort

What aggravates your symptoms?

_____

_____

What relieves your symptoms?

_____

_____

List three goals you'd like to accomplish with physical therapy:

1. _____

2. _____

3. _____