MOBILIZE PHYSICAL THERAPY

Refine Movement. Elevate Performance.

# MOBILIZE PHYSICAL THERAPY PATIENT QUESTIONNAIRE

Name: _____ (Last) _____ (First) _____ (MI) Date: _____

Preferred Gender Pronoun: he/him she/her they/them Occupation: _____

Patient Address: _____

Primary Care Physician: _____ Referring Physician: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone Number: _____

Employer: _____ Employer Phone Number: _____

Have you been involved in a car or work related accident that lead to your current injuries? ☐ Yes ☐ No

If yes please answer the following:

Claim Number: _____ Adjuster Name and Phone Number: _____

How did you hear about us?

What are you being seen for today?

How did your injury occur?

When did your symptoms begin?

Have you been diagnosed with any of the following conditions?

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

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

## MOBILIZE PHYSICAL THERAPY PATIENT QUESTIONNAIRE - PAGE 2

Surgical History: _____ Date: _____

Current Medications: _____

Are you seeing any other healthcare providers?

Have you had previous treatment for this condition?

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

- ☐ X-rays
- ☐ CT Scan
- ☐ Other
- ☐ MRI
- ☐ Bone Scan
- ☐ Nerve Conduction Study
- ☐ EMG

Results: _____

**Since the onset** of your symptoms have you had:

- ☐ Difficulty with bowel or bladder functional
- ☐ Dizziness or fainting
- ☐ Numbness in genital or anal area
- ☐ Vague feeling of bodily discomfort
- ☐ Fever/Chills
- ☐ Weakness
- ☐ Numbness
- ☐ Unexplained weight change
- ☐ Problems with vision/hearing
- ☐ Night pain/sweats

What aggravates your symptoms?

What relieves your symptoms?

Hobbies: _____

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

1. _____
2. _____
3. _____