Marcotte Physical Therapy, Inc.
501 Great Road, Suite 108, North Smithfield, RI 02896

Medical Health Questionnaire

Marcotte Physical Therapy prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.

Name: _____ Date of Birth: _____

Person Completing Form: _____ Medical Doctor: _____

Communication: Primary Language: □ English □ Other: _____ Interpreter Needed: □ Yes □ No
Do you require an alternative communication device (picture board/computer/etc)? □ Yes □ No
Hearing: □ Intact □ Impaired □ Hearing Aides Sign Language Interpreter Needed: □ Yes □ No
Vision: Require Corrective Lenses □ Yes □ No □ Reading Only Assistance Needed: □ Yes □ No

How do you learn best? □ Verbal □ Written □ Demonstration □ Other: _____
Would you like another person present for emotional support during your treatment? □ Yes □ No
Have you received PT, OT or Speech Therapy Services since January 1 of this year? □ Yes □ No

List other specialists you see: _____

Do you have an allergy to:	Describe reaction
Latex □ Y □ N	
Food(s) □ Y □ N	
Insect Bites □ Y □ N	
Band-Aids/Adhesive tape(s) □ Y □ N	
Medication(s) □ Y □ N	

Please List All Medications (Prescription, Non-Prescription, Vitamins and herbal Remedies):

Medication	Dosage	Frequency

Please List Any Surgical Procedure You Have Had (Including Implants):

Procedure (Implant)	Date (Year)	Location of surgery

Have you been told by your physician you have MRSA or VRE? □ Y □ N When: _____

Have You Had A Fall in the Past 6 Months? □ Y □ N When: _____
How may falls? _____

Do You Live Alone? □ Y □ N If Not Who With? _____
Are You the Primary Caregiver in Your Home? □ Y □ N If Not Who Is?_____

At the present time would you describe your health as: □ Excellent, □ Good, □ Fair, □ Poor?

Please Complete Medical Questionnaire on Reverse Side