PATIENT QUESTIONNAIRE / HEALTH HISTORY

Patient Name: Date:

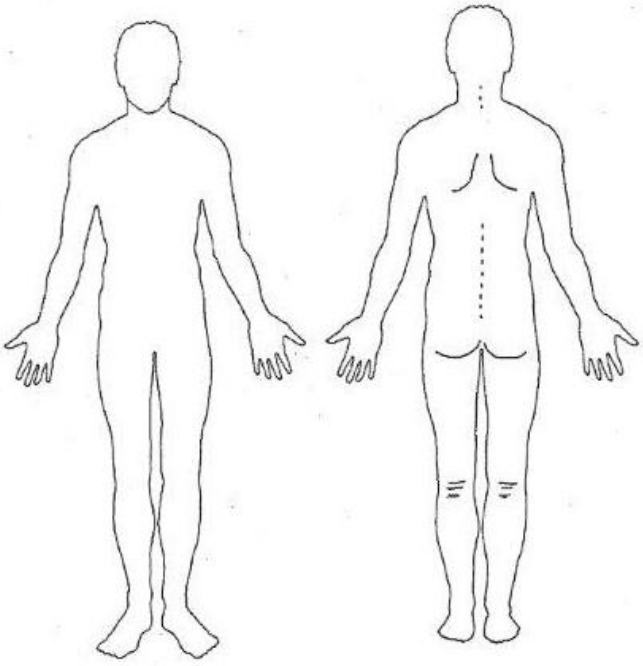
To ensure you receive a complete and thorough evaluation, please provide us with important background information on the following 2 pages. If you do not understand the questions, your therapist will assist you. Thank you.

HISTORY OF PRESENT CONDITION

What are your symptoms?_____

_____

Localize areas of pain or abnormal sensation on the body chart below (shade in where appropriate)



When did your symptoms begin? (*please indicate specific date, if possible)*_____

Was the onset of the episode ☐ Gradual ☐ Sudden

Briefly describe how your injury occurred *(if your condition is post-surgical please indicate)*_____

_____

_____

_____

Since onset, are your symptoms getting *(check one)*:
☐ better ☐ worse ☐ not changing

Have you had similar symptoms in the past? ☐ Yes ☐ No
More than one episode? ☐ Yes ☐ No

Nature of pain/symptoms *(check all that apply):*

☐ sharp	☐ aching	☐ constant
☐ dull	☐ periodic	☐ other_____
☐ throbbing	☐ occasional	_____

As the day progresses, do your symptoms *(check one)*:
☐ increase ☐ decrease ☐ stay the same

Does the pain wake you at night? ☐ Yes ☐ No
If *"yes,"* is it present ☐ while lying still
☐ only when changing positions
☐ both

Since the onset of your current symptoms have you had:
☐ any difficulty with control of bowel or bladder function
☐ fever/chills
☐ any numbness in the genital or anal areas
☐ numbness
☐ any dizziness or fainting attacks
☐ weakness
☐ unexplained weight change
☐ night pain/sweats
☐ malaise (vague feeling of bodily discomfort)
☐ problems with vision/hearing
☐ none of the above

What aggravates your symptoms *(check all that apply)*:

☐ Sitting	☐ Repetitive activities
☐ Going to/rising from sitting	☐ Household activities
☐ Lying down	☐ Standing
☐ Walking	☐ Squatting
☐ Up/down stairs	☐ Coughing/sneezing
☐ Reaching overhead	☐ Taking a deep breath
☐ Reaching in front of body	☐ Looking up overhead
☐ Reaching behind back	☐ Stress
☐ Reaching across body	☐ Sustained bending
☐ Talking/chewing/yawning	☐ Other_____
☐ Recreation/sports	_____

What relieves your symptoms? *(check all that apply)*

☐ Sitting	☐ Rest	☐ Massage
☐ Heat	☐ Standing	☐ Medication
☐ Cold	☐ Walking	☐ Nothing
☐ Stretching	☐ Exercise	☐ Other_____
☐ Wearing a splint/orthosis	☐ Lying down	_____

PATIENT QUESTIONNAIRE / HEALTH HISTORY

Patient Name: Date:

HISTORY OF PRESENT CONDITION

On a scale of 1 (no pain) to 10 (worst pain ever felt) what is your pain level: Currently _____
At it's worst_____

Have you had any previous treatments for this condition? *(check all that apply)*

- ☐ None
- ☐ Medication (oral)
- ☐ Joint manipulation
- ☐ Exercise
- ☐ Massage therapy
- ☐ Traction
- ☐ Bracing/taping
- ☐ Injection into the spine
- ☐ Injection into the skin/muscles
- ☐ Hypnosis
- ☐ Biofeedback
- ☐ TENS unit
- ☐ Acupuncture
- ☐ Bed rest
- ☐ Overnight hospitalization
- ☐ Casting
- ☐ Physical therapy
- ☐ Other_____

Have you had any of the following tests? *(check all that apply)*

- ☐ None
- ☐ X-rays
- ☐ CT Scan
- ☐ MRI
- ☐ Arthrogram
- ☐ Bone scan
- ☐ NCS / EMG
- ☐ Fluoroscope
- ☐ Vestibular
- ☐ Other_____

Test Results_____

Do you have any specifics goals that you want to accomplish during therapy? *(i.e. pain relief, return to sports, strengthening)*_____

MEDICATION

Are you currently taking any of the following **over the counter medications**? *(Check all that apply)*

- ☐ Aspirin
- ☐ Tylenol
- ☐ Vitamins/mineral Supplements
- ☐ Advil/Motrin/Ibuprofen
- ☐ Antihistamines
- ☐ Other_____

Please list any **perscription medications** you are currently taking *(pain pills, injections and /or skin patches, etc.)*

PAST MEDICAL HISTORY

Have you ever had/been diagnosed with any of the following conditions: *(check all that apply)*

- ☐ Cancer
- ☐ Depression
- ☐ Stroke
- ☐ Kidney problems
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ MS – Multiple Sclerosis
- ☐ Arthritis
- ☐ Head Injury
- ☐ Stomach problems
- ☐ Parkinson's disease
- ☐ Infectious diseases (i.e. hepatitis, TB, HIV, etc.)
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Lung problems
- ☐ Blood disorders
- ☐ Epilepsy / seizures
- ☐ Allergies
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Broken bone
- ☐ Circulation/Vascular problems
- ☐ Other_____

Please list any past surgeries:

Surgery	**Date**

WORK HISTORY

Occupation_____

- ☐ Employed full time
- ☐ Employed part time
- ☐ Self employed
- ☐ Homemaker
- ☐ Student
- ☐ Retired
- ☐ Unable to work
- ☐ Other_____

Physical Acitivies at work *(check all that apply)*

- ☐ Sitting
- ☐ Standing
- ☐ Phone use
- ☐ Repetitive lifting
- ☐ Heavy lifting
- ☐ Computer use
- ☐ Heavy equipment operation
- ☐ Driving
- ☐ Other_____

Hobbies & interests you have_____