PATIENT QUESTIONNAIRE/HEALTH HISTORY

Name:____Date:___________________________

To insure you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand the question or require assistance, please speak with your therapist. Thank you.

HISTORY OF PRESENT CONDITION

1. What are your symptoms?_________________________
____
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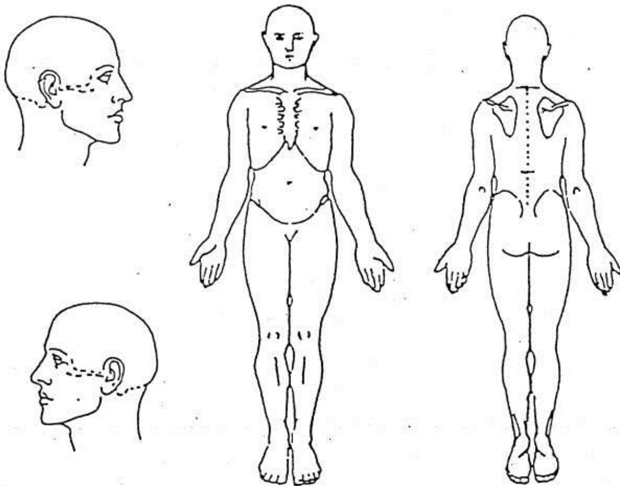
Please mark your areas of pain or abnormal sensation on the body chart below.



When did your symptoms begin?_____________________

3. Was the onset of this episode (check one):
   O gradual O sudden

4. Which of the following best describes how your injury occurred?
   O MVA (car accident)
   O lifting O work injury
   O fall O degenerative process
   O overuse O surgery
   O trauma O unknown
   O sport injury O other:_____________

5. Since onset, are your symptoms getting (check one):
   O better O worse O same

6. Have you had similar symptoms in the past? O yes O no
   More than one episode? O yes O no

7. As the day progresses, do your symptoms (check one):
   O increase O decrease O stay the same

8. Nature of pain/symptoms (check all that apply):
   O sharp O aching O constant
   O dull O periodic O other:_____________
   O throbbing O occasional _____________________

9. Does the pain wake you at night? O No O Yes
   If" yes", is it present: O while lying still
   O when changing positions

10. Do you have pain/stiffness upon getting out of bed in the morning? O Yes O No

11. In what position do you sleep? (check all that apply)
    O right side O stomach O recliner/chair
    O left side O back O other:_____________

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

13. What aggravates your symptoms? (check all that apply)
    O sitting O repetitive activities
    O going to/rising from sitting O household activities
    O lying down O standing
    O walking O squatting
    O up/down stairs O sleeping
    O reaching overhead O coughing/sneezing
    O reaching in front of body O taking a deep breath
    O reaching behind back O looking up overhead
    O reaching across body O swallowing
    O talking / chewing / yawning O stress
    O recreation/sports O other:_____________

14. What relieves your symptoms? (Check all that apply)

O sitting O rest O massage
O heat O standing O medication
O cold O walking O nothing
O stretching O exercise O other:_______________
O brace O lying down ____________________

15. Have you had any previous treatment for this condition?

O none O hypnosis
O medication O biofeedback
O chiropractor O TENS / electrical stimulation
O physical therapy O ultrasound
O exercise O acupuncture
O massage O bed rest
O traction O hospitalization
O bracing/taping O other:______________________
O injection ____________________________

16. Have you had any of the following tests?

O none O bone scan
O x-rays O nerve conduction study (NCS)
O CT scan O vestibular
O MRI O other:______________________
Test Results:_______________________________________

GENERAL HEALTH

How would you rate your general health?

O Excellent O Good O Average O Fair O Poor

How often do you exercise outside of normal daily activities?

O none O < 1x/wk O 1-2x/wk O 3-5x/wk O 6-7x/wk

If yes, what activities:___________________________________

Do you smoke: O Yes, ___packs/day O No

What is your stress level? O low O medium O high

Are you seeing any health care providers (other than physical therapist and referring physician) for this current condition?

Please list:____

PREVIOUS FUNCTIONAL LEVEL

O Independent with all activities (including work, community, home, recreation)

O Need assist with: O self-care (bathing, dressing, toileting, etc)
O household chores
O community activities (shopping, etc)

Hobbies:____

LIVING SITUATION

O live alone O house / apartment
O live with family/other O retirement complex/ALF
O live with caregiver O other:______________________

Setting: O stairs-railing O stairs-no railing O ramp
O ramp O elevator O uneven ground O other

MEDICATION

Please list all medications (prescription and over-the-counter) you are currently taking:________________________________
____
____
____

WORK HISTORY

Occupation:____

Work Status: O Unemployed O Student
O Full-time O Homemaker O Retired
O Part-time O Modified duty

Physical activities at work (check all that apply):

O sitting O lifting – heavy / repetitive
O standing O heavy equipment operation
O phone use O driving
O computer use O climbing
O other:____

Are you currently receiving or seeking disability for this condition? O Yes O No

Are you currently receiving or seeking worker's compensation for this condition? O Yes O No

PAST MEDICAL HISTORY

Have you ever had/been diagnosed with any of the following conditions? (Check all that apply)

O Cancer O Heart problems
O Depression O High blood pressure
O Stroke O Lung problems
O Kidney problems O Blood disorders
O Thyroid problems O Epilepsy / seizures
O Diabetes O Allergies
O Multiple sclerosis O Head injury
O Arthritis – osteo O Osteoporosis
O Rheumatoid arthritis O Broken bone
O Stomach problems O Poor circulation
O Parkinson's disease O Swelling
O Infectious disease (Hepatitis, TB, HIV, etc) O Other:______________ ______________

Please list any recent/relevant past surgeries:______________
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____
____