

PATIENT QUESTIONNAIRE/HEALTH HISTORY

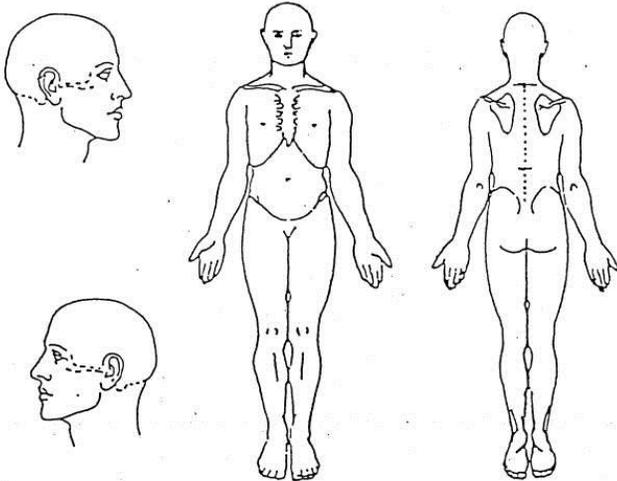
Name: _____ Date: _____

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? _____

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):

gradual sudden

4. Which of the following best describes how your injury occurred?

- lifting work injury
 fall degenerative process
 overuse surgery
 trauma unknown
 sport injury other: _____

5. Since onset, are your symptoms getting (check one):

better worse same

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

7. As the day progresses, do your symptoms (check one):

increase decrease stay the same

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

- sharp aching constant
 dull periodic other: _____
 throbbing occasional _____

9. Does the pain wake you at night? No Yes

- If "yes", is it present: while lying still
 when changing positions

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

11. In what position do you sleep? (check all that apply)

- right side stomach recliner/chair
 left side back other: _____

12. Since the onset of your current symptoms, have you had:

- difficulty with control of bowel or bladder function
 fever/chills
 numbness or tingling in the genital or anal area
 numbness
 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

13. 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 sleeping
 reaching overhead coughing/sneezing
 reaching in front of body taking a deep breath
 reaching behind back looking up overhead
 reaching across body swallowing
 talking / chewing / yawning stress
 recreation/sports other: _____

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

- sitting rest massage
- heat standing medication
- cold walking nothing
- stretching exercise other: _____
- brace lying down _____

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

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

16. Have you had any of the following tests?

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

GENERAL HEALTH

How would you rate your general health?

- Excellent Good Average Fair Poor

How often do you exercise outside of normal daily activities?

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

If yes, what activities: _____

Do you smoke: Yes, ___ packs/day No

What is your stress level? low medium high

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

Please list: _____

PREVIOUS FUNCTIONAL LEVEL

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

Need assist with: self-care (bathing, dressing, toileting, etc)

household chores

community activities (shopping, etc)

Hobbies: _____

LIVING SITUATION

- live alone house / apartment
- live with family/other retirement complex/ALF
- live with caregiver other: _____
- Setting:** stairs-railing stairs-no railing ramp
- ramp elevator uneven ground other

MEDICATION

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

WORK HISTORY

Occupation: _____

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

Physical activities at work (check all that apply):

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

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

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

PAST MEDICAL HISTORY

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

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

Please list any recent/relevant past surgeries: _____

