Patient Questionnaire
Health History

Name:_______________________

Height___________Weight__________

HISTORY OF PRESENT CONDITION

Treatment side: ☐ N/A ☐ Left ☐ Right

Surgery performed?: ☐ Yes ☐ No

Surgery Date(s):_________________________________

Surgery Type(s):________________________________

Hospitalization?: ☐ Yes ☐ No

Dates of Hospitalization:___________________________

Symptoms: ____________________________________

____

Primary Concerns:_______________________________

____

PREVIOUS FUNCTIONAL LEVEL

☐ **Independent in all activities**
☐ Able to participate in recreational activities

Hobbies: _________________________________
☐ Assisted with **self-care**
(hygiene, health-care, dressing, toileting)
☐ Assisted with **activities of daily life**
(shopping, house chores, transportation)
☐ Difficulty **changing or maintaining a body position**
- ☐ Transfers (lying to sitting; sit to stand)
- ☐ Standing, sitting, kneeling, squatting

☐ Assisted with **walking/moving around**
- ☐ Assisted device (cane, walker, wheelchair)

☐ Assisted with **carrying, moving, handling objects**

☐ Other:_____________________________________

CURRENT FUNCTIONAL LEVEL

Due to your injury you are having difficulty with:
☐ self-care
☐ activities of daily life
☐ changing or maintaining a body position
☐ walking/moving around
☐ carrying, moving, or handling objects

☐ Other:_____________________________________

SLEEP

In what positions do you normally sleep?

☐ Right Side ☐ Back ☐ Propped with pillows:
☐ Left Side ☐ Front ____________________

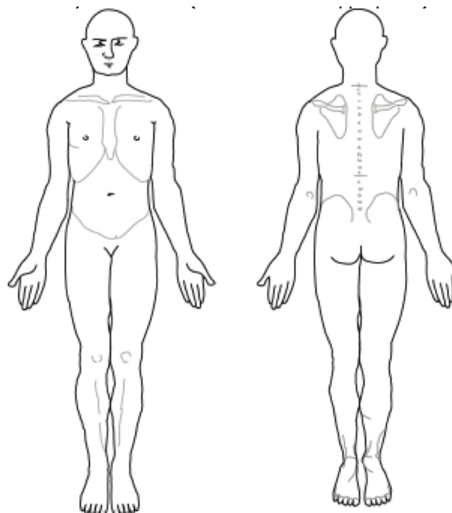
Surface: ☐ Firm ☐ Soft ☐ Other: _____

Does pain wake you or keep you up? ☐ Yes ☐ No

Hours of sleep per night:__________

PAIN

Localized areas of pain or abnormal sensation on the chart below
(shade where appropriate)



Please rate your pain level on a scale of 0-10
0 = no pain 10 = worst pain imaginable:

At worst:______ Current:______ At best:_______

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

☐ Burning ☐ Dull/Achy ☐ Sharp ☐ Intermittent
☐ Shooting ☐ Numb/Tingling ☐ Throbbing ☐ Constant

Worse with: ☐ AM ☐ Standing ☐ Stairs-Up
☐ PM ☐ Walking ☐ Stairs-Down

Other:______________________________

Better with: ☐ AM ☐ Standing ☐ Stairs-Up
☐ PM ☐ Walking ☐ Stairs-Down

Other:______________________________

Have you had similar symptoms in the past? ☐ Yes ☐ No

Number of Episodes: _________________

Year of First Episode:________________

Previous treatment for similar symptoms: ______________

____

How would you rate your general health? ☐ Excellent ☐ Fair ☐ Good ☐ Poor

Do you smoke / use tobacco? ☐ Yes ☐ No
Type/Amount:______________________

Have you had any recent falls? ☐ Yes ☐ No
How many?:________________________

Name:______________________

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WORK HISTORY

Occupation:___________________________________

☐ employed full time
☐ employed part time
☐ out of work
☐ Other:___________
☐ light-duty
☐ transitional duty
☐ homemaker
☐ not working

Duty Level: ☐ light ☐ medium ☐ heavy ☐ very-heavy

Physical activities at work: ☐ sitting ☐ standing ☐ driving ☐ Other: ☐ computer use ☐ phone use ☐ heavy equipment use ___________________

GENERAL MEDICAL HISTORY

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

☐ **No known significant past medical history**

☐ Osteoarthritis
☐ Cardiovascular Disease
☐ High Blood Pressure
☐ Blood Clots
☐ Asthma
☐ Diabetes Mellitus Type 1/ Type 2
☐ Latex Allergy
☐ Allergies:_________
____
____
☐ Cancer
Type:_______________________
Dates:______________________
☐ Current Infection
☐ Immunosuppression
☐ Osteoporosis
☐ Fracture or Suspected Fracture:___________________
☐ Cauda Equina Syndrome
☐ Unexplained Weight Loss
☐ Other/Describe:________________
____

SURGICAL / TREATMENT HISTORY

Please list any recent/relevant past surgeries or treatments related to your current problem:

☐ No recent or relevant past surgeries or treatments

Surgery / Treatment Date

____

____

____

DIAGNOSTIC TESTS

Have you had any of the following tests?

☐ none
☐ x-rays
☐ CT Scan
☐ MRI
☐ Arthrogram
☐ Bone Scan
☐ Fluroscope
☐ Vestibular

☐ Other:____

☐ Test Results:_______________________________________

____

MEDICATION

Please list any prescription medications you are currently taking (pills, injections, skin patches, inhalers, etc.)

____

____

____

____

____

Prescribing MD(s): Phone:

____

____

Are you currently taking any of the following over-the-counter medications?

☐ aspirin
☐ Tylenol
☐ Advil / Motrin / Ibuprofen
☐ corticosteroids
☐ antihistamines
☐ vitamins/mineral supplements:
____
____
____

☐ Other:____

____

GOALS

What are your goals for physical therapy? Please be as specific as possible:

____

____

____

____

Patient Signature: Date:

____

Therapist Signature: Date:

____