PHYSICAL THERAPY CLINIC

Patient Questionnaire

NAME: ___________________________ DATE: ___________________________

HEIGHT: ___________ WEIGHT: ___________

HISTORY OF PRESENT CONDITION

1. What are your current symptoms? ___________________________

Circle areas of pain or abnormal sensation on the body chart below:

2. When did your symptoms begin? (Please indicate a specific date if possible) ___________________________

3. Was the onset of this episode gradual or sudden? ☐ Gradual ☐ Sudden

4. How did your problem occur? (Example: a fall, a motor vehicle accident, don’t know)

5. Since onset, are your symptoms getting (check one): ☐ Better ☐ Worse ☐ Not Changing

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

☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Occasional ☐ Constant ☐ Shooting ☐ Other _______________

7. Does the pain wake you at night? ☐ No ☐ Yes

If yes, is it present: ☐ While lying still ☐ Only when changing positions ☐ Both

8. Please circle any of the following that are NEW, UNUSUAL, or ATYPICAL for you

YES NO fatigue
YES NO malaise
YES NO weakness
YES NO chills/sweats/fever
YES NO weight gain/loss
YES NO nausea/vomiting
8. CONTINUED

YES NO  tingling or numbness       YES NO  regular cough
YES NO  easy bruising            YES NO  difficulty breathing
YES NO  arm/leg swelling         YES NO  heart racing in your chest
YES NO  joint/muscle swelling    YES NO  difficulty swallowing
YES NO  dizziness/lightheadedness YES NO  heartburn/indigestion
YES NO  change in mention/cognitive abilities YES NO  constipation/diarrhea
YES NO  tremors                   YES NO  blood in stool
YES NO  seizures                 YES NO  post menopause
YES NO  double vision            YES NO  problems urinating (starting, burning)
YES NO  loss of vision           YES NO  urinary incontinence
YES NO  eye redness              YES NO  blood in the urine
YES NO  skin rash                YES NO  pregnant or might be pregnant
YES NO  problems sleeping        YES NO  stress at home or work

9. Have you had any previous treatment for any of the conditions listed above? If so, please explain:

GENERAL HEALTH

10. Which of the following have you taken in the past week:

Physician Prescribed

Aspirin
Tylenol
Anti-inflammatories (Advil/Motrin/Ibuprofen etc.)
Stomach ulcer medication
Vitamins/mineral supplements
Herbals/remedies

Anything NOT prescribed by a physician:________________________________________________________________________________________

Please list any other physician-prescribed medications you are currently taking (INCLUDING pills, injections, and/or skin patches):
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

11. How would you rate your general health?  □ Excellent  □ Average  □ Poor  □ Good  □ Fair

12. How often do you exercise outside of normal daily activities?

□ 4-5+ days/wk  □ 1-3 days/wk  □ occasionally  □ zero

13. Exercise/Sports/Recreation you do consist of:

________________________________________________________________________________________

14. Do you drink caffeinated beverages?  □ No  □ Yes  How many/much per day? ____________

15. Do you drink alcoholic beverages?  □ No  □ Yes  How many/much per day? ____________
16. Tobacco use: How many packs/day? _____ For how many years? ____ If quit, when? ____ Never smoked ______

17. What is your current stress level?  □ Low  □ Medium  □ High

18. Are you seeing any health care providers other than the physical therapist for this current condition? (Please list)

19. Have you EVER been diagnosed as having any of the following conditions?

   YES NO  Cancer. If YES, what kind: ________________________________
   YES NO  Heart Problems. If YES, what kind: __________________________
   YES NO  High blood pressure
   YES NO  Circulation problems
   YES NO  Asthma
   YES NO  Stomach ulcers
   YES NO  Chemical dependency (alcohol or drug)
   YES NO  Thyroid problems
   YES NO  Epilepsy/seizures
   YES NO  Diabetes
   YES NO  Multiple sclerosis
   YES NO  Rheumatoid arthritis
   YES NO  Other arthritic conditions
   YES NO  Depression
   YES NO  Hepatitis
   YES NO  Tuberculosis
   YES NO  Stroke
   YES NO  Kidney disease. If YES, what kind: ___________________________
   YES NO  Blood Clots
   YES NO  Osteoporosis
   YES NO  Other: ___________________________________________________

20. Please list any recent or past surgeries related to your current problem:
    Surgery                                                                                   Date
    ___________________________________________________________________________________
    ___________________________________________________________________________________
    Any other surgeries:
    ___________________________________________________________________________________

20. Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

   YES NO  Diabetes
   YES NO  High blood pressure
   YES NO  Heart Disease
   YES NO  Arthritis
   YES NO  Stroke
   YES NO  Osteoporosis
   YES NO  Cancer
   YES NO  Psychological condition
   Other: ______________________________________________________________________________

FAMILY HISTORY

20. Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

   YES NO  Diabetes
   YES NO  High blood pressure
   YES NO  Heart Disease
   YES NO  Arthritis
   YES NO  Stroke
   YES NO  Osteoporosis
   YES NO  Cancer
   YES NO  Psychological condition
   Other: ______________________________________________________________________________