GEORGE FOX UNIVERSITY
PHYSICAL THERAPY CLINIC

Patient Questionnaire

NAME:_____DATE:_____

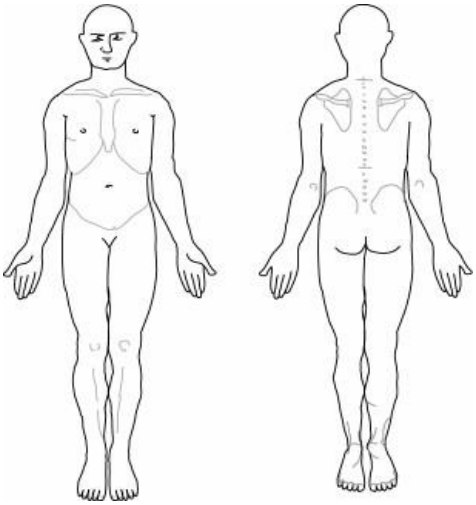
HEIGHT: _____ WEIGHT:_____

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	chills/sweats/fever
YES NO	malaise	YES NO	weight gain/loss
YES NO	weakness	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	YES/NO
Tylenol	YES/NO
Anti-inflammatories (Advil/Motrin/Ibuprofen etc.)	YES/NO
Stomach ulcer medication	YES/NO
Vitamins/mineral supplements	YES/NO
Herbals/remedies	YES/NO

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:

_____

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_____