South Whidbey Physical Therapy
& Sports Clinic

HEALTH QUESTIONNAIRE

Name: _____ Date: _____

1. **What problem are you here for today?** _____
2. **Date this problem started?** _____
3. **Did this happen at work?** ☐ YES / ☐ NO
4. **Have you had a problem previously, similar to the one you are here for today?** ☐ YES / ☐ NO
5. **Have you had any previous treatment for this condition?** ☐ YES / ☐ NO
   If yes, When: _____ Where: _____
6. **Height: _____ Weight: _____ Age: _____**
7. **Please check any of the following tests performed for the condition you are here for today:**
   ☐ X-Rays ☐ CAT Scan ☐ Bone Scan ☐ Electromyelogram ☐ MRI ☐ Nerve Conduction Study
   ☐ Other (please list): _____
   ☐ Know the results: _____
8. **Since the onset of your symptoms have you had:**
   ☐ changes with bowel/bladder function ☐ numbness of groin/buttocks ☐ fever/chills ☐ night pain/sweats
   ☐ numbness ☐ dizziness/fainting ☐ weakness ☐ unexplained weight changes ☐ malaise (overall body discomfort)
   ☐ locking ☐ dislocating ☐ giving way ☐ loss of balance ☐ swelling ☐ pain with cough/sneeze
9. **Do you participate in regular fitness/exercise routine?** ☐ YES / ☐ NO
   If yes, how many days per week? _____ Please describe: _____
10. **Past medical history - Have you ever been diagnosed with any of the following conditions:**
    ☐ Cancer (type) _____ ☐ Depression ☐ Stroke ☐ Arthritis ☐ Lung problems ☐ Osteoporosis
    ☐ Asthma ☐ Diabetes ☐ Broken bones ☐ Sprains/Strains ☐ Seizures ☐ Blood clots ☐ Osteopenia
    ☐ Headaches ☐ High blood pressure ☐ Heart disorder ☐ Nerve Disorder ☐ _____
11. **Current medications:** (Please list dosage for each or attach a separate sheet if needed): _____
    _____
12. **List any previous surgeries and/or hospitalizations:** _____
13. **Have you had any long term use of Prednisone, Cortisone, steroids, or inhalants**? ☐ YES / ☐ NO
14. **Allergies?** (Please list): _____
15. **List 3 goals you have for physical therapy:**
    1. _____
    2. _____
    3. _____