WHERE MOVEMENT AND LIFE COME TOGETHER

PHYSICAL THERAPY CLINIC Patient Questionnaire

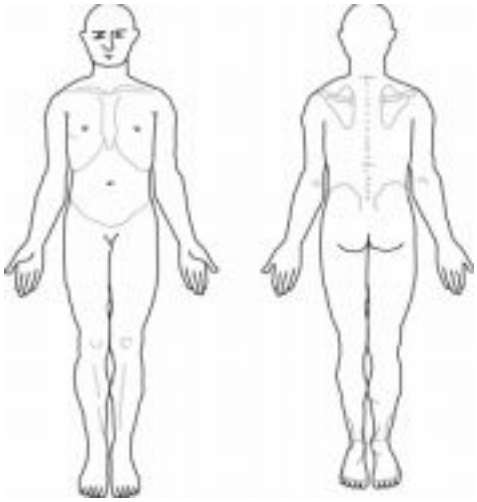
NAME:_____DATE:_____
Height:_____Weight:_____

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 check 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
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 Cancer
☐YES ☐NO High blood pressure ☐YES ☐NO Psychological condition ☐YES ☐NO Heart Disease ☐YES ☐NO Osteoporosis ☐YES ☐NO Arthritis ☐YES ☐NO Stroke
Other_____
_