PHYSICAL THERAPY GENERAL HEALTH QUESTIONNAIRE

Name:_____ _____ **Reason for therapy?**_____

Check all the Conditions that apply to you:

HEART/CIRCULATION	√	MEDICAL PROBLEMS	√	FOR WOMEN ONLY	
Heart Disease		Diabetes		***CHILDBEARING HISTORY***	
High Blood Pressure		Fainting Spells		Are you Pregnant? Yes No	
Pacemaker		Cancer		If yes, what is your due date:_____	
Heart Surgery		Dizziness		If no, are you trying to get pregnant? Yes No	
Pain/tightness in chest		Thyroid Problems		If yes, are you planning to breastfeed?	Yes No Don't Know
Stroke		Falls the last 6 mos.		# of Pregnancies – If this is your first pregnancy, skip the next section	0 1 2 3 4 5 +
BONES & JOINTS		# trips/slips/near falls			
Osteoporosis		Depression		***COMPLETE THE SECTION BELOW ONLY IF YOU HAVE HAD MORE THAN ONE PREGNANCY.***	
Scoliosis		**LUNG/BREATHING**			
Fibromyalgia		Difficulty breathing		# of Children (circle one number)	0 1 2 3 4 5 +
Plantar fascitis		Shortness of Breath			
Dropped arches/flat feet		Smoke cigarettes now		# of Miscarriages (circle one number)	0 1 2 3 4 5 +
Numbness in feet/legs		History of smoking		# of Vaginal deliveries (circle)	0 1 2 3 4 5 +
Tailbone fracture		**SURGICAL HISTORY**			
Joint Replacements		Back or neck		# of C-Sections (circle one number)	0 1 2 3 4 5 +
Swelling in Ankles/feet		Tubal Ligation			
AREAS OF PAIN		Laproscopy		Birth weight of largest baby	
Back ("sciatica like pain")		Abdominal Hysterectomy			
Neck		Vaginal Hysterectomy		# of episiotomies (circle one number)	0 1 2 3 4 5 +
Ribs		Gall Bladder			
Shoulders		Bladder surgery		# of forceps deliveries	0 1 2 3 4 5 +
Abdomen/belly					
Tailbone		**FAMILY HISTORY**		Do you have symptoms of leaking urine	Yes No
Wrist ("carpal tunnel")		Heart Disease		Do you have constipation	Yes No
Swelling in the hands		High Blood Pressure		Do have pain with sexual intercourse	Yes No
Feet		Diabetes			
Knees		Cancer			
Hips		Stroke			
Leg		Osteoporosis			
Arm					

LIST ALL THE MEDICATIONS YOU ARE TAKING, INCLUDING HERBAL AND OVER THE COUNTER MEDICATIONS:

Name of Medication	For what?	Name of Medication	For What?
1.		**5.**	
2.		**6.**	
3.		**7.**	
4.		**8.**	

SOCIAL, OCCUPATIONAL AND RECREATIONAL ACTIVITIES

Marital Status: __Single __Married ___Separated __Divorced __ # of people that live with you:_____

Do you feel safe at home? ___Yes ____ No Comment:_____

Occupation:_____ Physically this means I ___sit ___stand __walk most of the day

Educational Level _____ **Hobbies**: _____ _____

EXERCISE HISTORY:
___No exercise ___Walk _____ ____Go to gym _____

Other_____

CHECK THE WORDS THAT APPLY TO HOW YOU FEEL THESE DAYS &/OR CHOOSE YOUR OWN WORDS:

DESCRIPTOR	√		√		√		√		√		√		√
Happy →		Calm →		Unmotivated		Stressed		Lonely		Content		Depressed	
Overwhelmed →		Sad →		Tired		Afraid		Energetic		Optimistic		"Postpartum blues"	
Flabby →		Strong →		Un-rested		Lethargic		Weak		Overworked		Not bonding with baby(ies)	
Anxious →		Unsafe →		Abused		Neglected							

HOW DO YOU LEARN?: ___Listening (lecture, discussion) ___Seeing (read, video, DVD) __Doing (practicing skill)

Is English your primary language? ___Yes ____No. If no, would you need a translator when you are in therapy? _____

NUTRITION:
How much do you weigh? _____pounds

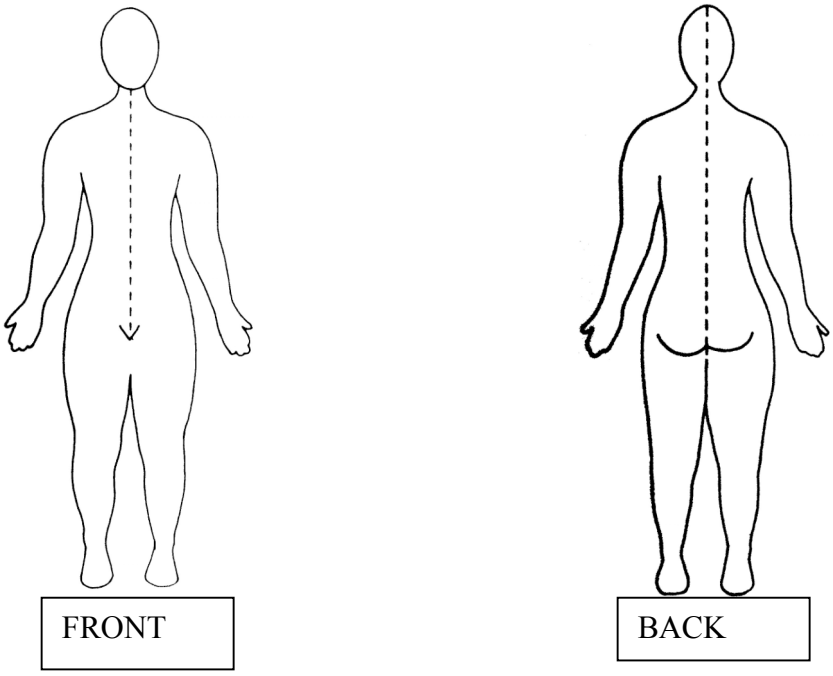
		If you answered YES, please explain
Would you like to ___lose or ____gain weight?	Yes No	How many pounds?_____
Have you gained more than 10 pounds in the last year?	Yes No	How many pounds?_____
Have you lost more than 10 pounds in the last year?	Yes No	How many pounds?_____
Are you on any special diet?	Yes No	__Low Carb ___Atkins ___South Beach __Weight Watchers __Diabetic __Other_____
Would you say your diet is "unhealthy"?	Yes No	__too many fast foods __Not enough vegetables __High Fat __High Carb __Other_____

FLUID INTAKE: What do you drink every day?
____8 ounce glasses of water ___cans of diet soda ___cans of regular soda ___8 ounce cups of regular coffee
____8 ounce cups of decaffeinated coffee ____8-ounce cups/glasses of tea ____16-ounce cans of beer
____glasses of wine ___glasses of liquor ___ 8-ounce glasses of milk ____8-ounce glasses of juice_____
____Other_____

Anything else you would like us to know about you?_____

TELL US ABOUT YOUR PAIN

Please mark with an "X" where your pain begins. Shade any other areas of pain



CHECK ALL THE WORDS THAT DESCRIBE YOUR PAIN:

___Numb ___Stabbing ___Burning ___Irritating ___Aching ____Throbbing ___Tender ___Unbearable ___Shooting
___Sharp __Constant __Other_____

WHAT MAKES YOUR PAIN WORSE:

___Sitting ___standing ___Walking ___Getting out of bed ___exercise ___sexual intercourse ___menses
___Getting up from sitting position ___Working at home all day ___Being at work all day ___Exercise
___Other_____

WHAT MAKES YOUR PAIN BETTER:

____Heating pad ___Ice pack ___Resting in bed ___Resting in Chair ___walking ___Medication ___Exercise
____Other _____

CHECK ALL THE STATEMENTS THAT ARE TRUE:

____ I have numbness or tingling in my legs ____I have numbness or tingling in my arms or hands
____ There is a change in the way my bladder or bowels work since this problem started
____ I feel dizzy ___I have blurred vision.

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? ____None or:

TREATMENTS	HAS IT HELPED?	TREATMENTS	HAS IT HELPED?
Medication(s)	Yes No A little	Physical Therapy	Yes No A little
Chiropractic	Yes No A little	Other	Yes No A little
Surgery	Yes No A little	Other	Yes No A little

WHICH ACTIVITIES DO YOU HAVE DIFFICULTY WITH? (check column that describes your level of ability)

Key *0=Able to do with no difficulty* *1= Able to do with a little difficulty* *2= Able to do with moderate difficulty* *3=Able to do with lot of difficulty* *4=Unable to do at all* *NA= Not applicable*

	0	1	2	3	4	NA
Example: Walking short distances		√				
Exercise/Walking						
Exercise (in gym, aerobics, fast paced walking, jogging)						
Walk - short distances (in grocery store, 1-2 blocks)						
Walk – long distances (more than quarter mile)						
Climbing stairs at work or home (how many stairs_____)						
Static Body Positions						
Able to sit comfortably for work, movie, driving, TV (2-3 hours)						
Able to stand comfortably for work, housework, errands (2-3 hrs.)						
Able to sleep 5-7+ hours continuously not interrupted by pain						
Self Care and Care of Family						
Light housework (dishes, cooking small meals, laundry)						
Heavy housework (vacuuming, mopping, sweeping, bed making)						
Personal hygiene (dressing, toileting, bathing)						
Able to take care of infants/toddlers						
Able to take care of school age children						
Able to lift light objects (5-10 lbs)						
Able to lift heavy objects (20+ pounds, including children)						
Bending/stooping (reach lower cabinets, pick up objects off floor)						
Activities of Daily Living						
Able to drive a car						
Able to turn neck to reverse the car						
Ability to Concentrate/focus						
Ability to work at job as required						
Able to enjoy social life (worship, visit with friends, eat out, vacation)						
Able to travel short distances to work, grocery, bank (1-2 hours)						
Able to travel for long distances (more than 2 hours)						
Ability to read books, newspaper, magazines						
Using Arms/Hands						
Grasping						
Holding small objects (pencil, pen, key)						
Keyboard (computer, video games, calculator, cash register)						
Reaching overhead cabinets						
Reaching behind back (to fasten bra or dry back after bath)						
Pushing (grocery cart, bins, strollers, other)						
Pulling						
Carrying (grocery sacks, laundry baskets, child in car seat)						

Comments: _____