

Patient History

Thank you for thoroughly completing this questionnaire. The information that you supply will expedite the evaluation process and help us to focus on your specific needs.

Patient Name: _____ Phone #: _____ Patient DOB: _____

Address: _____

Male: ___ Female: ___ Right handed: ___ Left handed: ___

Approximate height: ___ft. ___in. Approximate weight: _____lbs.

Cultural / Religious:

Do you have any customs, beliefs, or other cultural or religious factors that might affect your Physical

Therapy treatment? _____

Education:

Highest grade completed (please circle one): 1 2 3 4 5 6 7 8 9 10 11 12

- some college/technical
- college graduate
- graduate school

Employment:

Occupation: _____

- full-time
- part-time
- homemaker
- student
- retired
- currently unemployed

Home:

Where do you live?

- | | |
|--|--|
| <input type="checkbox"/> Private home/apartment | <input type="checkbox"/> Alone |
| <input type="checkbox"/> Rented room | <input type="checkbox"/> Spouse |
| <input type="checkbox"/> Assisted living/group home | <input type="checkbox"/> Spouse and others |
| <input type="checkbox"/> Senior apartment | <input type="checkbox"/> Parents |
| <input type="checkbox"/> Long-term care/nursing home | <input type="checkbox"/> Child |
| <input type="checkbox"/> Other _____. | <input type="checkbox"/> Other relative |

- Group care
- Personal care attendant
- Other _____.

With whom do you live?

Does your home have:

- Stairs with railing
- Stairs without railing
- Ramps
- Elevator
- Obstacles, please describe them: _____.

Walking:

Do you use:

- Cane
- Walker
- Manual wheelchair
- Motorized wheelchair
- Scooter
- Other: _____.

General Health:

Please rate your overall health:

- Excellent
- Good
- Fair
- Poor

Health Habits:

a) Exercise

Do you exercise regularly? Yes ___ No ___ How often? ___ days / (please circle one) week month.

How long? ___ minutes / session.

What is your preferred form of exercise?

- Walking
- Bicycling
- Running
- Swimming
- Other _____.

b) Smoking

Do you smoke? Yes ___ No ___. # cigarettes / day ___. # cigars / day ___.

Have you smoked in the past? Yes ___ No ___. How long? _____. Year quit: _____.

c) Alcohol

How many days per week, on average, do you drink alcohol? _____ # drinks / day ___.

Family History (please indicate whether your father, mother, sister / brother, aunt / uncle, grandmother / grandfather and the age of onset if known):

- Heart disease _____
- High blood pressure _____
- Stroke _____
- Diabetes _____
- Cancer _____
- Other _____

Medications:

Please list or allow us to copy your list of all **prescription** medications you are currently taking _____

_____.

Please list or allow us to copy your list of all **non-prescription** medications that you take on a regular basis _____

_____.

Medical History:

Have you ever had surgery? (please list procedure and date)

Procedure _____ Date _____

Procedure _____ Date _____

Procedure _____ Date _____

Procedure _____ Date _____

Please check any health conditions that do now or have previously applied to you:

- Allergies
- Arthritis
 - Osteoarthritis
 - Rheumatoid arthritis
- Broken bones / fractures
- Cancer
- Circulatory / vascular disorders
- Depression
- Developmental or growth disorders
- Diabetes / high blood sugar
- Head injury
- Heart problems
- High blood pressure
- Low blood pressure
- Infectious disease (such as tuberculosis, hepatitis, etc.)
- Kidney disorders
- Low blood sugar / hypoglycemia
- Lung or breathing disorders
- Multiple sclerosis
- Osteoporosis
- Parkinson's disease
- Repeated infections
- Seizures / epilepsy
- Skin diseases
- Stroke / CVA
- Thyroid problems
- Ulcers / stomach problems
- Other: _____

Within the past year, have you had any of the following medical tests?

(Please check all that apply)

- Angiogram
- Arthroscopy
- Biopsy
- Blood tests
- Bone scan
- Bronchoscopy
- CT scan
- Doppler ultrasound
- Echocardiogram
- EEG (electroencephalogram)
- EKG (electrocardiogram)
- EMG (electromyogram)
- Mammogram
- MRI
- Myelogram
- NCV (nerve conduction velocity)
- Pap smear
- Pulmonary function test
- Spinal tap
- Stool tests
- Stress test (bicycle or treadmill)
- Urine tests
- X-ray

Are you currently scheduled for or has your Physician ordered any medical tests? Yes ___ No ___

Which test has been ordered? _____

History of Current Problem:

When did the problem begin? _____

What happened? _____

Have you had this problem before? Yes ___ No ___ When? _____ How long did it last? _____

What did you do for the problem the last time? _____

Did the problem get better? Yes ___ No ___

What are you doing for the problem now? _____

What makes the problem worse? _____

What makes the problem better? _____

What activities are you unable to do now that you could do before? _____

What are your goals for physical therapy? _____

Are you seeing any other practitioners for this problem? (Please check all that apply)

- Acupuncturist
- Cardiologist
- Chiropractor
- Dentist
- Family Practitioner
- Internist
- Massage Therapist
- Neurologist
- Obstetrician / Gynecologist
- Occupational Therapist
- Orthopedist
- Osteopath
- Physical Therapist
- Pediatrician
- Rheumatologist
- Other _____