Patient Questionnaire

NAME:_____

What are you being seen for today? _____
When (roughly) did your symptoms start? _____
What do you think caused your symptoms? _____
Have you had this problem before? _____

Have you had any of the following treatments for these symptoms?
□Previous PT (including in your home) □Chiropractor □Occupational Therapy
□Psychologist/psychiatrist □Massage Therapy

Have you had any of the following tests/procedures for these symptoms?
□X-Ray □MRI □CT Scan □blood test □ultrasound □injections □bone scan □other_____

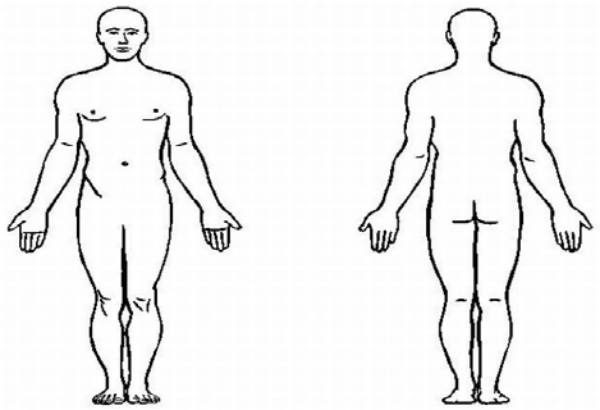
Are your symptoms: □Constant □Intermittent □Change with activity

List three things that make your symptoms worse _____

List three things that make your symptoms better _____

How are you sleeping?
□Not sleeping □Difficulty falling asleep □Wake up due to pain □Sleep with meds

(Mark on the picture the location of your worst symptoms)



Pain: Better: □a.m. □p.m. □night
Worse: □a.m. □p.m. □night

Work: □employed □unemployed □retired □student □homemaker
Occupation: _____ Hours worked per day:_____
Work requirements: □lifting □sitting □computer □phone □driving
□overhead □prolonged standing □other_____

Social History:
Lives □alone □with Spouse/Partner □Family_____ □with Caregiver
Lives in □apartment □house □assisted living
□# stairs_____ □railing Y/ N

Current Exercise Routine/ Leisure activities/ Hobbies:_____
How often do you exercise? _____days per week

What are your expectations for therapy? _____

Therapist Signature_____ Date _____

NAME:_____

Past Medical History

Have you ever been diagnosed by a physician as having any of the following conditions?

□Alzheimer's
□Anemia
□Anxiety/ Panic attacks
□Artery blockage
□Arthritis
□Asthma
□Blood Clot
□Bone/ Joint Infection
□Chemical dependency (alcoholism/drugs)
□Cancer *Type*_____*When*_____
□Coronary artery disease
□COPD
□Dementia
□Depression
□Diabetes
□Emphysema/ Bronchitis
□Epilepsy/Seizures
□Fibromyalgia
□Gastrointestinal disorder
□Gout
□Gynecological problem
□Hard of hearing
□Heart attack
□Heart problems
□Hernia
□Hepatitis/Liver problems
□HIV/AIDS
□High blood pressure
□Incontinence
□Kidney disease
□Migraines
□Mental illness
□Multiple sclerosis
□Organ Transplant
□Osteoporosis
□Pacemaker
□Pneumonia
□Stroke
□Swelling/ edema
□Tuberculosis
□Tumor
□Thyroid problem
□Vision changes
□Other_____

Women: Are you currently pregnant or think you might be pregnant? Yes No

List Surgeries/hospitalization □ See List
1._____
2._____
3._____

List injury/fracture/dislocation/sprain
1._____
2._____
3._____

List Prescription medication (pill, injection, skin patches) □ See List
1._____ 2._____ 3._____4._____
5._____ 6._____7._____ 8._____

List over the counter medications taken in the last week
1._____ 2._____ 3._____ 4._____

Number of caffeinated beverages/pills do you have per day _____ Tobacco use per day _____
How many days a week do you drink alcohol? _____ drinks per episode_____

Allergies: Medication: _____ Other: _____
Latex Allergy: YES NO Sensitivity to Heat or Ice: YES NO

Have you recently noted? *(If so, is your doctor aware of this? If not, be prepared to discuss with your therapist.)*

□Unexplained weight loss/ gain
□Weakness
□Dizziness/ lightheadedness
□Heart burn/indigestion
□Shortness of breath
□Fainting
□Headache
□Nausea/ vomiting
□Fever/ chills/ sweats
□Numbness/ tingling
□Difficulty swallowing
□Constipation
□Diarrhea
□Fatigue
□Changes in bladder/ bowel function
□Falls_____ number in past year
□Balance difficulty with walking

In the past month have you felt down or had little interest/pleasure in doing things? YES NO

Do you feel you are in an unsafe or abusive relationship? YES NO
Do you want help with this? YES YES, but not today NO

Therapist Signature_____ Date _____