



PATIENT HISTORY QUESTIONNAIRE

Date _____

CHART # _____

Patient _____ Nickname _____
FIRST MIDDLE LAST

Your therapist will discuss your responses with you during the evaluation. Thank you for completing this information.

PERSONAL INFORMATION

I am currently: Employed Employed with restrictions On medical leave Not employed

I currently: Live alone Live with caregiver Live with family members

Current living environment: Home/apartment Retirement home Assisted living

Do you smoke? Yes No Packs per day _____ Do you drink alcohol? Yes No Drinks per week _____

Do you exercise? Yes No Type _____ Times per week _____

Interests/hobbies/exercise _____

Will you have any problems attending therapy sessions? Yes No

GENERAL HEALTH

Medical conditions you currently have or have had in the past (check all that apply):

Allergies Arthritis/Gout Blood Disorder Cancer Circulation/Vascular Problems Heart Disease

Depression Diabetes Epilepsy/Seizures Fibromyalgia Head Injury Hearing Problems

High Cholesterol/Lipids Recent Hospitalization Hypertension Infectious Disease Kidney Disease

Liver Disease Lung Disease Migraines Multiple Sclerosis Osteoporosis Pacemaker

Panic Attacks/Anxiety Parkinson's Disease Stomach Disease/Ulcer/Reflux Stroke/Paralysis

Thyroid Disease Visual Problems Surgery – type(s) _____

If female, are you currently pregnant? Yes No

Are you taking any medications? Yes No If yes, please list _____

Have you had any prior treatments for your current condition (check all that apply)?

Hospitalization Bracing/Taping/Casting Physical Therapy Surgery TENS/Stimulation Unit

Injections Chiropractics Acupuncture Other _____

Are you having trouble sleeping? Yes No Normal hours of sleep: _____ hours Current hours of sleep: _____ hours

PREVIOUS FUNCTIONAL LEVEL

Before the onset of my current symptoms (or prior to injury), I was: Independent in all activities Dependent for all care

Independent with self-care only Needing assistance with some activities Needing assistance with most activities

PERSONAL GOALS FOR THERAPY

What do you want to achieve from having therapy? Reduce Pain Increase Function Return to Work

Return to usual housework/yard work Return to recreation, types _____

Sleep without waking up Other _____

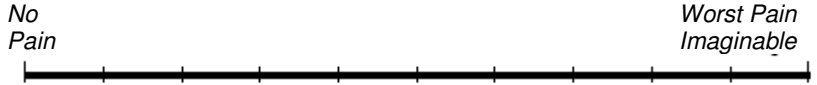
KEY QUESTIONS ABOUT YOUR CONDITION

What is your MAIN complaint? _____

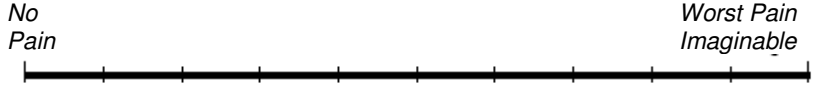
Darken the areas on the body where you are having problems:

Please mark your level of pain with an **X** along the following lines:

What is your level of pain at rest?

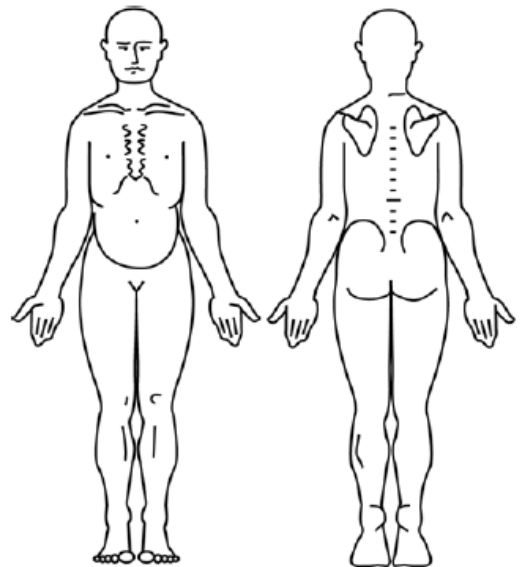


What is your pain with activity?



How would you describe your pain (check all that apply)?

- Aching Burning Cramping Crushing Discomfort Dull
- Gnawing Loss of Sensation Numbness Pressure Sharp
- Stabbing Stinging Swollen Throbbing Tight Tingling Weakness Other _____



When and how did these symptoms begin? _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

Since the onset of your symptoms have you had any of the following (check all that apply)? Significant, unexplained weight loss

Atypical night pains Impaired bowel/bladder function Pain in multiple areas Dizziness/fainting Muscle weakness

Fever/chills Numbness Visual/Hearing Problems