HEALTH QUESTIONNAIRE

Print Your Name:_____Age_____

*Height:*_____ *Weight:*_____
Please circle : Are you right-handed or left-handed?
Please circle: English understood/ Interpreter needed/ Language you speak most often?_____
Highest grade completed (*circle one*) 1 2 3 4 5 6 7 8 9 10 11 12 some college / college graduate / graduate school / advanced degree

CURRENT CONDITION(S) / CHIEF COMPLAINT(S)

Describe the problem for which you seek physical therapy:_____

_____

Is the current problem the result of (*please circle*): **Work Accident / Auto Accident / Other Accident / Unknown / Other**

When did the problem(s) begin (Date)?_____

What happened?_____

Have you ever had the problem(s) before? YES or NO If yes, what did you do for the problem (s)? _____

_____

Did the problem(s) get better? YES or NO

How are you taking care of the problem(s) now?_____

What makes the problem(s) better?_____

What makes the problem(s) worse? _____

What are your goals for physical therapy? _____

Name of Doctor prescribing physical therapy?_____ Date of next MD appt?_____

Have you had Physical Therapy or are you seeing anyone else for the problem(s)? (chiropractor, etc):_____

Are you currently receiving **HOME HEALTH**? Or have you had **HOME HEALTH** recently? Yes or No _____
(is any healthcare worker, nurse or aide or provider coming to your home?) If Yes, Whom?_____

CLINICAL TESTS have you had any of the following test(s) recently? *Please circle all that apply*

Arthroscopy	X-rays	Stress test (treadmill, bicycle)
NCV (nerve conduction velocity)	Doppler Ultrasound	Myelogram
EKG (electrocardiogram)	Bone Scan	MRI
EMG (electromyogram)	CT Scan	Other _____

MEDICATIONS:
Separate list Provided? YES or NO If NO please list ALL medications with dosage & frequency below
this includes prescription, over the counter drugs, herbal and nutritional supplements you take routinely and/or on an as needed basis.

Medication /Drug Name	Dosage	Number of Times per Day & Route

MEDICAL/SURGICAL HISTORY *please circle if you have ever had or currently have-*

PACEMAKER/DEFIBRILLATOR		Lung problems	Parkinson disease
Broken bones/fractures	Stroke	Seizures/epilepsy	Skin diseases
Osteoporosis	Diabetes/high blood sugar	Developmental/growth problems	Depression
Arthritis	Low blood sugar/hypoglycemia	Thyroid problems	Cancer
Circulation/vascular problems	Blood disorders	Infectious disease (eg.TB,hepatitis)	Head injury
Heart problems	Multiple Sclerosis	Kidney problems	Ulcer/stomach problems
High blood pressure	Muscular dystrophy	Repeated infections	Other _____

Within the past year, have you had any of the following symptoms?
Please circle all that apply

Chest pain	Coordination problems	Difficulty sleeping	Urinary problems
Heart palpitations	Weakness in arms or legs	Loss of appetite	Fever/chills/sweats
Cough	Loss of balance / Falls	Nausea/vomiting	Headaches
Hoarseness	Difficulty walking	Difficulty swallowing	Hearing problems
Shortness of breath	Joint pain or swelling	Bowel problems	Vision problems
Dizziness or blackouts	Pain at night	Weight loss/gain	Other_____

Have you ever had surgery? If yes, please describe and include dates:_____

_____

Do you have any known allergies? *Please circle* Yes or No, *If Yes please list*:_____

For women only-Are you pregnant or think you might be? *Please circle* Yes or No

GENERAL HEALTH STATUS
Please rate your health by *circling one answer*: Excellent / Good / Fair / Poor
Have you had any major life changes during the past year? (eg. new baby, job change, death of a family member)_____

HEALTH HABITS
Do you currently use tobacco products? *Please circle* Yes or No
If yes what type and how much per day?_____

FUNCTIONAL STATUS/ACTIVITY LEVEL *Please check all that apply*
___Difficulty with locomotion/movement
___Difficulty with self-care (such as bathing, dressing, eating, toileting)
___Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependants
___Difficulty with community and work activities
___work/school ___recreation or play activity
Do you exercise beyond your normal daily activities and chores? *Please circle* Yes or No
If yes describe the exercise_____
On average, how many days per week do you exercise or do physical activity?_____
For how many minutes, on an average day?_____

SOCIAL HISTORY
With whom do you live? _____Where do you live? (eg home, assisted living)_____
Does your home have: *please circle*

Stairs, no railing	Ramps	Uneven terrain	Any obstacles_____
Stairs, railing	Elevators	Assistive devices_____	

Do you use: *please circle*

Cane	Manual wheelchair	Crutches	Glasses	Other:
Walker	Motorized wheelchair	Hearing aids	Contacts	_____

Employment: *please circle*

Working full-time outside the home	Working part-time outside the home	Homemaker	Retired
Working full-time from home	Working part-time from home	Student	Unemployed

Occupation (description of type of work you perform)_____

Signature of Patient or Legal Representative_____ Date_____

(For office use only: reviewed &verified by PT _____ *Date*_____