# HEALTH QUESTIONNAIRE AND MEDICAL HISTORY

Patient Name: _____ Date_____

Reason for Therapy: _____ Date of onset: _____

If you were injured, please describe how._____

_____

_____

What makes your pain feel better (positions, activities)?_____

_____

What makes your pain feel worse (positions, activities)?_____

_____

What are your goals for physical therapy? _____

_____

What is your occupation? _____ How many hours per week do you work? _____

What does a typical day involve physically (standing, sitting, driving, lifting, etc.) ?

_____

IF you have dependents: responsible for physical care of (circle)

young child(ren) elderly parent spouse disabled person(s)

IF you use stairs at work or home: how many stairs/flights?_____

(Circle all that apply:) Inside stairs : One rail/Two rails # of stairs /flights _____

Outside stairs: One rail/ Two rails # of stairs/flights_____

Describe your exercise routine, if any: _____

Are you or were you active in any sports? If so, which sports, and when?_____

_____

Surgical History:

| Date | Surgery | Physician |
|---|---|---|
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| | | |

Do you now have, or have you ever had, any of the following?

| YES | CONDITION | PLEASE EXPLAIN | YEAR OF DIAGNOSIS |
|---|---|---|---|
| | Allergies | | |
| | Arthritis (osteoarthritis, DJD) | | |
| | Arthritis (rheumatioid) | | |
| | Asthma | | |
| | Exercise induced asthma | | |
| | Bleeding disorders | | |
| | Blood clots | | |
| | Cancer | | |
| | Circulation problems | | |
| | Diabetes (specify type I or II) | | |
| | Fainting | | |
| | Falls | | |
| | Headaches | | |
| | Hearing problems | | |
| | Heart disease | | |
| | Hernia | | |
| | High blood pressure | | |
| | Kidney disease | | |
| | Lung disease / COPD | | |
| | Metal implants | | |
| | Motor Vehicle Accident | | |
| | Nervous disorder | | |
| | Orthopedic problems (broken bones, sprains, etc) | | |
| | Pacemaker | | |
| | Pregnancy (presently) | | |
| | Sensitivity to tape/ice/heat | | |
| | Seizures | | |
| | Sleep disorders | | |
| | Swallowing problems | | |
| | Stroke | | |
| | Thyroid disease | | |
| | Vision problems | | |
| | Wound healing problems | | |

Please list all medications you are currently taking, including over the counter and herbal medications.

| MEDICATION | DOSAGE | CONDITION/WHY USED |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

HAVE YOU FALLEN WITHIN THE LAST YEAR? _____

IF (YES) WHAT WAS THE DATE & CIRCUMSTANCES?

_____

_____

Please list any other relevant health information which may affect your physical therapy treatment: _____

_____
_____
_____
_____
_____
_____
_____
_____