Health History and Patient Questionnaire

Issue(s) you are here to address: ____

When did your pain start or your injury occur? ____

What happened to cause your pain and/or injury? ____

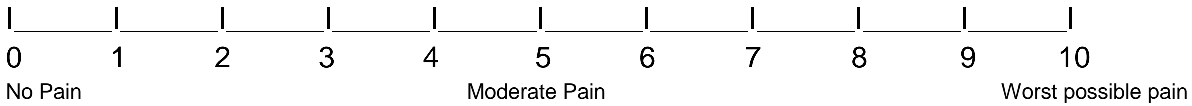
What makes your symptoms worse? ____

What makes your symptoms better?

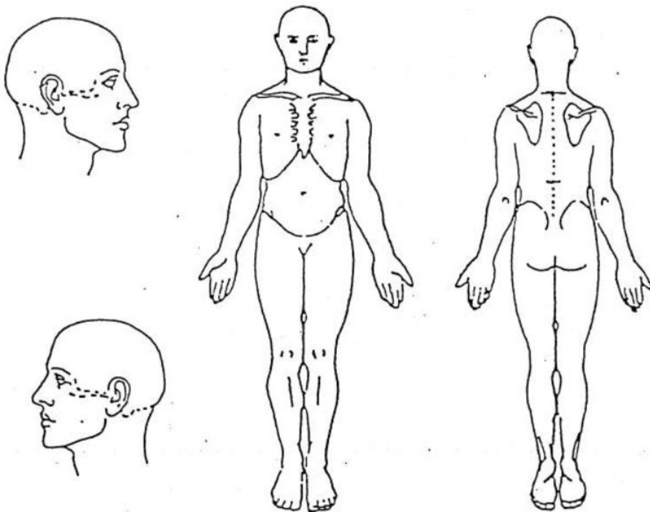
____

Describe your symptoms (Mark all that apply): ▢ Burning ▢ Sharp ▢ Dull/Ache ▢ Throbbing ▢ Numbness
▢ Tingling ▢ Stabbing ▢ Shooting ▢ Tight/Stiff ▢ Constant ▢ Intermittent
Other: ____

On a scale of 0-10 what is your pain at rest?________ At its worst?_________ Current? _____________



Please mark on the body diagram your areas of pain:



Are your symptoms getting: ▢ Better ▢ Worse ▢Not changing

Any other notes about your symptoms? ____

Do you have pain with any of the following? (Please circle):

Sleep Standing Sitting Walking Bending Stairs:up/down/both Cough/Sneeze
Reach/Push/Pull Lifting/Carrying Running Sports/Wellness activities Worse in AM/PM

Diagnostic tests: ▢ X-rays ▢ MRI ▢ EMG ▢ CT Scan Other:______________________________________
Specific Findings/Results:____

Any History of Falls? ▢ Yes ▢ No
If yes, when was your last fall and what happened? ____

What would you like to accomplish with physical therapy? What are your goals?

____

____

Personal History

Please check each as it applies to you. Have you ever had:

▢ Cardiac Pacemaker	▢ Seizures	▢ Rheumatoid Disease
▢ Cardiovascular Disease	▢ Headaches	▢ Fibromyalgia
▢ Emphysema	▢ Depression/Anxiety/Bipolar	▢ Peripheral Neuropathy
▢ High/Low Blood Pressure	▢ Shortness of breath	▢ Vision problem
▢ Diabetes	▢ Fractures	▢ Unexplained weight loss
▢ Stroke	▢ Asthma	▢ Arthritis
▢ Gout	▢ Hernia	▢ Osteopenia/Osteoporosis
▢ Cancer	▢ Bowel/bladder changes	▢ Multiple Sclerosis
▢ Night Pain	▢ Allergies	▢ Dizziness

Please give dates and explanation of any/all marked conditions:

____

____

Surgical History: ____

____

Have you had physical therapy in this calendar year? ____

Any other medical problems? If so, please describe:

____

____

Current medications/vitamins/supplements: ____

____

____

Family History:

Check as it applies to a blood relative: ▢ High Blood Pressure ▢ Stroke ▢ Diabetes ▢ Heart Disease

Height: _____________________________________ Weight: ________________lbs

Do you smoke? Yes No Do you consume alcohol? Yes No If yes, how much? _____ drinks per week/month