PATIENT HEALTH HISTORY (CONFIDENTIAL)

NAME: ________________________________ **DATE:** __________

The following questionnaire is designed to assist your physical therapist in providing you with a comprehensive and accurate examination. Please assist us by providing the following background information. If you do not understand a question, your physical therapist will assist you. Thank you.

1. What are your symptoms? ____
____

2. When did your symptoms begin (please list date as accurately as possible) ____________________________

3. Briefly describe your injury or the events leading to your symptoms __________________________________
____

4. Have you had similar symptoms in the past? ☐Yes (approximate date) __________________ ☐No

5. Have you had surgery on the body region associated with your current symptoms? ☐Yes ☐No

6. Are you taking medications for this condition? ☐ Yes (please list):____________________________ ☐ No

7. Please list any other medications your are currently taking: ____
____

8. Since the onset of your current symptoms, have you had any of the following? (Check all that apply)
   - ☐ Difficulty with bowel or bladder function
   - ☐ Numbness in the genital or anal area
   - ☐ Numbness elsewhere
   - ☐ Dizziness or fainting
   - ☐ Weakness
   - ☐ Foot drop
   - ☐ Unexplained weight change
   - ☐ Night pain/night sweats
   - ☐ Problems with vision and/or hearing
   - ☐ None of the above

9. What previous (or current) treatment(s) have you had for this condition?
   - ☐ None
   - ☐ Physical therapy
   - ☐ Massage therapy
   - ☐ Chiropractic
   - ☐ Traction
   - ☐ Injection to spine
   - ☐ Injection to muscles or skin
   - ☐ Surgery
   - ☐ TENS unit
   - ☐ Exercise
   - ☐ Bracing/taping/casting (please circle)
   - ☐ Overnight hospitalization
   - ☐ Bed rest
   - ☐ Acupuncture
   - ☐ Other

10. Have you had any of the following for this condition?
   - ☐ X-rays
   - ☐ MRI
   - ☐ CT scan
   - ☐ Arthrogram
   - ☐ Diagnostic ultrasound
   - ☐ Bone scan
   - ☐ Bone density test
   - ☐ Blood/urine tests
   - ☐ EMG
   - ☐ Nerve conduction test
   - ☐ Other

Test results: ____

11. Please list any activities you can’t do, or do only with significant pain/difficulty, as a result of this condition:
____
____

12. Do you have access to exercise/pool facilities: ☐ Yes ☐ No

13. Please list the type(s) of exercise you do, and their frequency: ______________________
____
____

14. Do you smoke? ☐ No ☐ Yes

15. How would you rate your general health? ☐Excellent ☐Good ☐Average ☐Fair ☐Poor

16. What goals would you like to achieve from physical therapy? ______________________
____
____

17. Are you currently working? ☐Yes ☐No ☐Full-time ☐Part-time ☐Restricted duty

18. What is your perceived stress level? ☐Low ☐Medium ☐High

19. Please indicate if you have had, or currently have, any of the following medical conditions:

☐ Heart problems/disease
☐ Pacemaker or deep brain stimulator
☐ Cancer (type) ____________________
☐ Diabetes
☐ Multiple sclerosis
☐ High/low blood pressure (please circle)
☐ Circulatory/vascular disorders
☐ Stroke/CVA
☐ Head injury
☐ Epilepsy/seizures
☐ HIV/AIDS
☐ Other infectious diseases
☐ Rheumatoid arthritis
☐ Osteoarthritis
☐ Fibromyalgia
☐ Osteoporosis
☐ Kidney disorder
☐ Parkinson’s disease
☐ Respiratory ailments
☐ Allergies
☐ Orthopedic injuries (i.e., bone fractures)
☐ Joint replacement(s)
☐ Neurological disorder(s)
☐ Chemical dependency
☐ Eating disorder
☐ Depression
☐ Pregnancy (currently or suspect you may be)
☐ Other ____________________

20. Please list any past surgeries or other relevant medical procedures, with approximate dates: __________
____
____

By signing below I attest that all of the information I have provided is true and accurate to the best of my knowledge.

Patient signature: ________________________________ Date: ______________
Parent/Guardian signature: ___________________________ Date: ______________
(If under age 18)