PATIENT HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ DOB: _____ Evaluation Date: _____

SUBJECTIVE

1. General Info: Age: _____ years Weight: _____ lbs Height: ____ ft ___ in
2. Please list the symptoms for which you are seeking PT:_____
3. When did your symptoms start? _____
4. How did your symptoms start? _____
5. Is the current injury related to:
   ☐Work ☐ Motor Vehicle Accident ☐ Previous injury/exacerbation ☐ Sports ☐ Post Surgical ☐ Other _____
6. Are your symptoms: Improving ____ Getting worse____ Staying the same ____
7. Have you ever had these symptoms before? Yes ___ No____If yes, please describe: _____
8. Have you ever had testing for these symptoms? (*check all that apply)*
   XRays ___ MRI ___CT Scan ____ EMG/Nerve Conduction Studies ____Other _____
   Results: _____
   Have you ever had treatment before for these symptoms? Yes_____ No____ If Yes, please describe:
   - Medication: Beneficial? Yes __No __Explain:_____
   - Physical Therapy: Beneficial? Yes __No __Explain:_____
   - Other: Beneficial? Yes __No __Explain:_____
9. Have you ever had surgery for this condition? Yes _____ No _____ If yes, Date of surgery: _____
   What surgical procedure was performed? _____

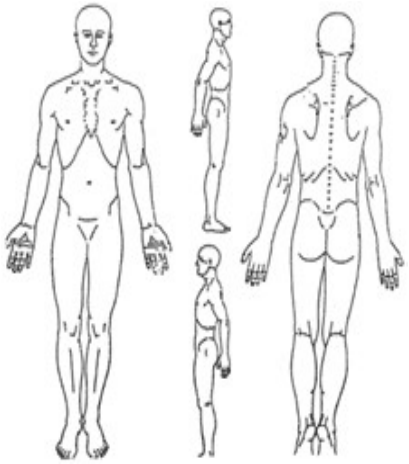
PAIN/SYMPTOM DESCRIPTION

1. On a scale from 0-10 (0 = "no pain" & 10 = "worst pain imaginable"), what is your pain level?
   At best: ____ At worst: _____ On average: _____

2. Please describe your discomfort:
   □ Constant □ Intermittent □ Ache □ Deep □ Superficial □ Dull □ Sharp
   □ Cramping □ Shooting □ Burning □ Numbness/Tingling □ Decreased Feeling
   □ Other: _____

3. Please check any other symptoms you might have:
   □ Stiffness □ Loss of Motion □Pressure □ Swelling □ Popping □ Clicking
   □ Giving way □ Locking □ Spasms □ Dizziness □ Fainting□ Nausea

4. What makes your symptoms better?_____
5. What makes your symptoms worse? _____



Please indicate the location(s) of your discomfort

FUNCTIONAL/SOCIAL HISTORY

1. What is your current living arrangement? □ Alone □ Spouse □ Partner □ Family □ Other: _____
2. Does your home have stairs? □ Yes □ No If Yes, # of stairs: _____

EXERCISE	STRESS LEVEL	SOCIAL HABITS
○ None	○ Low	Smoking Packs a day: _____
○ 1-2 x Week	○ Medium	Alcohol Drinks per week: _____
○ 3-4 x Week	○ High	Latex Allergy: ___Yes ___No
○ 5+ x Week		

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3. Please list your TOP THREE functional activities that you were able to complete prior to this injury but are having difficulty completing currently in an efficient, typical, competent, and expected manner
   (i)_____ (ii) _____ (iii)_____

WORK HISTORY

1. Occupation: _____ Currently working? Yes __ No ___
2. If Yes, □ Full Duty □ Limited Duty: Restrictions: _____
3. What are your job duties? (*Check all that apply*)
   □ Sitting □ Computer Work □ Bending □ Heavy Lifting □ Traveling □ Standing □ Reaching □ Crawling □ Twisting
   □ Walking □ Pushing/Pulling □ Gripping/Pinching □ Other: _____
4. Does your current injury impact your work? If so, please describe _____

MEDICATION HISTORY

In terms of your general health, please check ALL that apply:

□ Allergies	□ Recent Nausea/Vomiting	□ Heart Palpitations
□ Metal Implants/Artificial Joints	□ Seizures/Epilepsy	□ Chest Pain/Angina
□ Respiratory Problems	□ Recent Vision Changes	□ Hernia
□ Recent Headaches	□ Recent Dizziness/Fainting	□ Depression
□ High Blood Pressure	□ Recent Change in Bowel/Bladder Habits	□ Surgeries
□ Hypoglycemia	□ Intolerance to Cold/Heat	□Kidney Problems
□ Unexplained Weight Loss/Gain	□ Pregnancy (Currently)	□ Heart Disease
□ Diabetes I or II	□ Recent Unexplained Fatigue	□ Numbness/Tingling in Hip/Buttocks Area
□ Heart Attack	□ Ringing of the Ears	□ Liver/Gallbladder Problem
□ Osteoarthritis	□ Fibromyalgia	□ Recent Fractures
□ Osteoporosis	□ Night Pain	□ Rheumatoid Arthritis
□ Pacemaker	□ Pain with Cough/Sneeze	□ Anemia
□ Cancer	□ Stroke/TIA	

5. Have you had any **falls** in the past 12 months? □ Yes □ No If Yes, how many? _____
   Please describe the nature of the fall(s) and any injuries from it:
   _____

Clinic Notes:
Fall Risk: Yes___ No ___

MEDICATIONS

Please provide a list **all** of the medications [with specific NAME, DOSAGE, FREQUENCY, and ROUTE (ie: by mouth)] that you are currently taking [including over-the-counter, prescriptions, herbals, and vitamins/mineral(s)]:

_____
_____

Clinic Notes
□ See Attached List
_____
_____
_____

PATIENT GOALS FOR THERAPY

What are your **goals** for participating in Therapy? (I.E: performing household tasks without pain)

_____

SIGNATURE: To the best of my knowledge I have fully informed you of the history of my problem and current status.

Patient's Signature: _____ PT Signature_____ Date: _____