

## PATIENT HEALTH HISTORY QUESTIONNAIRE

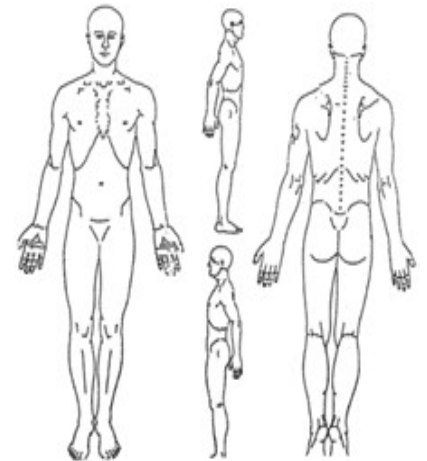
Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Evaluation Date: \_\_\_\_\_

### 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
<ul style="list-style-type: none"> <li><input type="radio"/> None</li> <li><input type="radio"/> 1-2 x Week</li> <li><input type="radio"/> 3-4 x Week</li> <li><input type="radio"/> 5+ x Week</li> </ul>	<ul style="list-style-type: none"> <li><input type="radio"/> Low</li> <li><input type="radio"/> Medium</li> <li><input type="radio"/> High</li> </ul>	Smoking Packs a day: _____ Alcohol Drinks per week: _____ Latex Allergy: ___Yes ___No

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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:

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

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: \_\_\_\_\_