PATIENT HISTORY QUESTIONNAIRE

CHART # ____________________

Date ______________________

Patient ____ Nickname _________________
FIRST MIDDLE LAST

Your therapist will discuss your responses with you during the evaluation. Thank you for completing this information.

PERSONAL INFORMATION

I am currently: ☐Employed ☐ Employed with restrictions ☐ On medical leave ☐ Not employed

I currently: ☐ Live alone ☐ Live with caregiver ☐ Live with family members

Current living environment: ☐ Home/apartment ☐ Retirement home ☐ Assisted living

Do you smoke? ☐ Yes ☐ No Packs per day ______ Do you drink alcohol? ☐ Yes ☐ No Drinks per week _______

Do you exercise? ☐ Yes ☐ No Type _______________________________________ Times per week __________________

Interests/hobbies/exercise ____

Will you have any problems attending therapy sessions? ☐ Yes ☐ No

GENERAL HEALTH

Medical conditions you currently have or have had in the past (check all that apply):

☐ Allergies ☐ Arthritis/Gout ☐ Blood Disorder ☐ Cancer ☐ Circulation/Vascular Problems ☐ Heart Disease

☐ Depression ☐ Diabetes ☐ Epilepsy/Seizures ☐ Fibromyalgia ☐ Head Injury ☐ Hearing Problems

☐ High Cholesterol/Lipids ☐ Recent Hospitalization ☐ Hypertension ☐ Infectious Disease ☐ Kidney Disease

☐ Liver Disease ☐ Lung Disease ☐ Migraines ☐ Multiple Sclerosis ☐ Osteoporosis ☐ Pacemaker

☐ Panic Attacks/Anxiety ☐ Parkinson's Disease ☐ Stomach Disease/Ulcer/Reflux ☐ Stroke/Paralysis

☐ Thyroid Disease ☐ Visual Problems ☐ Surgery – type(s) ____

If female, are you currently pregnant? ☐ Yes ☐ No

Are you taking any medications? ☐ Yes ☐ No If yes, please list ____

____

Have you had any prior treatments for your current condition (check all that apply)?

☐ Hospitalization ☐ Bracing/Taping/Casting ☐ Physical Therapy ☐ Surgery ☐ TENS/Stimulation Unit

☐ Injections ☐ Chiropractics ☐ Acupuncture ☐ Other __________________________________

Are you having trouble sleeping? ☐ Yes ☐ No Normal hours of sleep: ______hours Current hours of sleep: _____hours

PREVIOUS FUNCTIONAL LEVEL

Before the onset of my current symptoms (or prior to injury), I was: ☐ Independent in all activities ☐ Dependent for all care

☐ Independent with self-care only ☐ Needing assistance with some activities ☐ Needing assistance with most activities

PERSONAL GOALS FOR THERAPY

What do you want to achieve from having therapy? ☐ Reduce Pain ☐ Increase Function ☐ Return to Work

☐ Return to usual housework/yard work ☐ Return to recreation, types ____

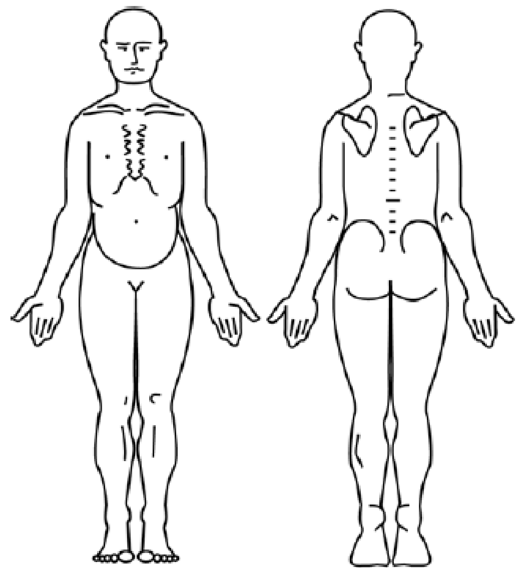
☐ Sleep without waking up ☐ Other ____

KEY QUESTIONS ABOUT YOUR CONDITION

What is your MAIN complaint? ___________________________________

____

Darken the areas on the body where you are having problems:



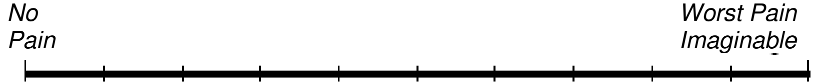
Please mark your level of pain with an **X** along the following lines:

What is your level of pain at rest?

No Pain *Worst Pain Imaginable*

What is your pain with activity?

No Pain *Worst Pain Imaginable*



How would you describe your pain (check all that apply)?

☐ Aching ☐ Burning ☐ Cramping ☐ Crushing ☐ Discomfort ☐ Dull

☐ Gnawing ☐ Loss of Sensation ☐ Numbness ☐ Pressure ☐ Sharp

☐ Stabbing ☐ Stinging ☐ Swollen ☐ Throbbing ☐Tight ☐ Tingling ☐ Weakness ☐ Other ________________________

When and how did these symptoms begin? ____

What makes your symptoms worse? ____

____

What makes your symptoms better? ____

____

Since the onset of your symptoms have you had any of the following (check all that apply)? ☐ Significant, unexplained weight loss

☐ Atypical night pains ☐ Impaired bowel/bladder function ☐ Pain in multiple areas ☐ Dizziness/fainting ☐ Muscle weakness

☐ Fever/chills ☐ Numbness ☐ Visual/Hearing Problems