Patient Questionnaire – Physical Therapy

1. Name: _____

2. Date of Birth: _____
3. Age: _____ **Sex:** _____
4. Height: _____ **Weight:** _____

5. Date of Injury (If applicable) _____

6. Date of Last Doctor Visit: _____
Date of Next Doctor Visit: _____

7. Have you ever had Physical Therapy?
Yes **If yes, name of Physical Therapy clinic: and year:** _____
No

8. Have you had Home Health services this calendar year?
Yes **If yes, which agency provided your Home Health Care and have you been discharged?** _____
_____
No

9. Employment:
Full-time Occupation: _____
Part-time _____
Homemaker Student
Retired Unemployed
Disabled due to: _____

10. General Health
a. Please rate your health:
Excellent Good Fair Poor

b. How many times have you fallen over the past year? _____
Did you sustain an injury? _____

c. Women – Are you currently pregnant?
Yes No

11. Health habits
a. Do you exercise beyond normal daily activities/chores?
Yes No
If yes, please describe the exercise: _____
_____
b. How many days per week do you exercise? _____
c. For how many minutes, on an average day? _____

d. Do you currently smoke tobacco? Yes No
e. If yes, do you smoke:
Cigarettes Number of packs per day _____
Cigars Number per day _____

12. Medications
a. Do you take any prescription medications? Yes No
If yes, please list: _____
_____
_____
_____

b. Do you take any nonprescription medications? (Check all that apply.)
Advil/Ibuprofen
Antacids
Aleve/Naproxen
Antihistamines
Asprin
Decongestants
Herbal Supplements
Tylenol
Other _____
_____

13. Medical History
a. Please check if you have ever had:
Allergies to latex or tape
Arthritis
Blood Disorders
Broken Bones/Fractures
Cancer
Circulation/Vascular Problems
Depression
Developmental or Growth Problems
Heart Problems
Infectious Disease
Diabetes/High Blood Sugar
High Blood Pressure
Low Blood Sugar/ Hypoglycemia
Lung Problems
Osteoporosis
Seizures/Epilepsy
Skin Diseases
Stroke
Other _____
_____

14. Please list surgeries with date:
_____ _____
_____ _____
_____ _____

15. Are you experiencing any of the following symptoms?
(Check all that apply.)
Pain or Feeling of Heaviness in your Chest
Heart Palpations
Shortness Of Breath
Loss Of Appetite/Unexplained Weight Loss
Coordination Problems/Loss Of Balance
Frequent Nausea/Vomiting
Change in or Problems with Bladder/Bowel Function
Difficulty Swallowing or Changes in Speech
Dizziness Or Blackouts
Vision or Hearing Problems
Fever/Chills/Sweats
Frequent or Severe Headaches

16. Within the past year, have you had any of the following medical tests? (Check all that apply.)

MRI X-Rays
Bone Scan CT Scan
Lung Function Test: Heart Function Test:
Other: _____

17. History of Current Problem

a. When did the current problem begin? (date)_____

b. What happened? _____

_____

c. Are you seeing anyone else for the problem? _____

_____

d. Are you currently involved in litigation or do you have an attorney regarding your current injury? Yes No

18. Functional Status (Check all that apply and list specifics):

Difficulty with bed mobility
Difficulty with transfers (such as moving from bed to chair)
Difficulty with gait (walking)
On level ground On uneven terrain
Going down stairs Going up stairs

_____

Difficulty with self-care activities (such as bathing, dressing, eating, toileting)

_____

Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependents)

_____

Difficulty with work/school

_____

Difficulty with recreation or play activity

_____

19. What are your personal goals for therapy?

_____ Relieve/reduce pain
_____ Learn self-care techniques and prevention
_____ Resume/improve self-care activities (dressing, hair, etc.)
_____ Resume/improve household chores (vacuuming, cleaning, etc.)
_____ Resume/improve yard work, gardening, etc.
_____ Return to work activities, specify _____
_____ Return to sports, recreation, hobbies; specify _____
_____ Improve sleep
_____ Improve posture
_____ Regain mobility/increase flexibility
_____ Regain strength/increase strength
_____ Increase sitting tolerance
_____ Increase walking distance and speed
_____ Other: _____

_____

_____

_____