Core Physical Therapy LLC

PATIENT QUESTIONNAIRE / HEALTH HISTORY

Name: _____ Date: _____

To insure you receive a complete and thorough evaluation, please provide us with your health history on the following form.

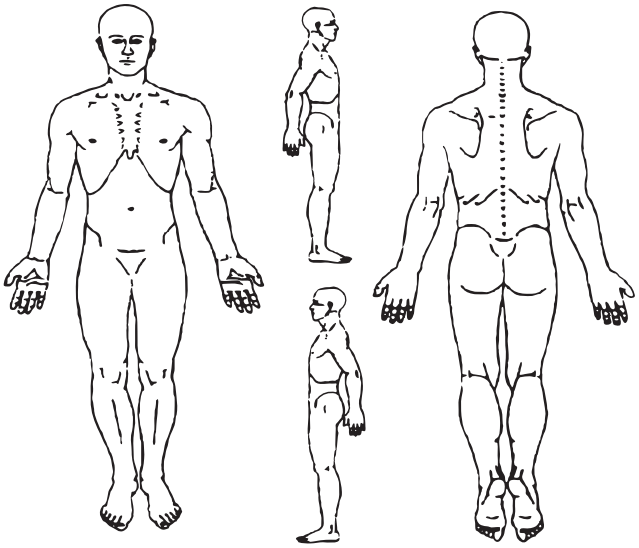
HISTORY OF PRESENT CONDITION

1. What are your symptoms? _____

_____

_____

Localize areas of **pain** or **abnormal** sensation on the body chart below (Shade in where appropriate)



What is your pain level right now?

No Pain — Worst Imaginable Pain

1 2 3 4 5 6 7 8 9 10

Is your pain:

Dull / Achy / Burning / Tingling / Sharp / Shooting / Numbing / Stabbing

2. Which of the following *best describes* how your injury occurred?

- ☐ lifting
- ☐ car accident
- ☐ a fall
- ☐ work incident
- ☐ overuse (cumulative trauma)
- ☐ running
- ☐ throwing
- ☐ sports injury
- ☐ home accident
- ☐ a pull on the arm
- ☐ degenerative process
- ☐ trauma
- ☐ unknown
- ☐ other _____

3. When did your symptoms begin?

(Please indicate a specific date if possible) _____

4. Was the onset of this episode gradual or sudden? (check one)

☐ gradual ☐ sudden

5. Since onset, are your symptoms getting: (check one)

☐ better ☐ worse ☐ not changing

6. Have you had similar symptoms in the past year?

☐ Yes ☐ No

More than one episode? ☐ Yes ☐ No

7. Nature of pain/symptoms (check all that apply)

- ☐ sharp
- ☐ aching
- ☐ constant
- ☐ dull
- ☐ periodic
- ☐ other _____
- ☐ throbbing
- ☐ occasional

_____

8. As the day progresses, do your symptoms: (check one)

☐ increase ☐ decrease ☐ stay the same

9. Does the pain wake you up at night? ☐ No ☐ Yes

If "yes", is it present

- ☐ while lying still
- ☐ only when changing positions
- ☐ both

10. Do you have pain/stiffness upon getting out of bed in the morning?

☐ Yes ☐ No

11. In what position do you sleep? (check all that apply?)

- ☐ right side
- ☐ stomach
- ☐ chair/recliner
- ☐ left side
- ☐ back
- ☐ other _____

_____

12. What aggravates your symptoms? (check all that apply)

- ☐ sitting
- ☐ going to/rising from sitting
- ☐ lying down
- ☐ walking
- ☐ up/down stairs
- ☐ sustained bending
- ☐ reaching in front of body
- ☐ reaching behind back
- ☐ reaching across body
- ☐ looking up overhead
- ☐ reaching overhead
- ☐ standing
- ☐ squatting
- ☐ sleeping
- ☐ household activities including:_____
- ☐ repetitive activities
- ☐ recreation/sports
- ☐ coughing/sneezing
- ☐ talking, chewing, yawning, (circle all that apply)
- ☐ taking a deep breath
- ☐ swallowing
- ☐ stress
- ☐ other _____

13. What relieves your symptoms? (check all that apply)

- ☐ sitting
- ☐ standing
- ☐ stretching
- ☐ lying down
- ☐ walking
- ☐ exercise
- ☐ rest
- ☐ heat
- ☐ cold
- ☐ medication
- ☐ massage
- ☐ nothing
- ☐ other _____

14. Since the onset of your current symptoms have you had:

a change in your health	☐ Yes	☐ No
shortness of breath	☐ Yes	☐ No
upper respiratory infection	☐ Yes	☐ No
difficulty swallowing	☐ Yes	☐ No
weakness	☐ Yes	☐ No
changes in bowel or bladder functions	☐ Yes	☐ No
urinary tract infections	☐ Yes	☐ No
changes in appetite	☐ Yes	☐ No
unexplained weight changes	☐ Yes	☐ No
fever/chills/night sweats	☐ Yes	☐ No
night pain	☐ Yes	☐ No
dizziness/fainting attacks	☐ Yes	☐ No
nausea/vomiting	☐ Yes	☐ No
numbness or tingling	☐ Yes	☐ No
malaise (vague feeling of bodily discomfort)	☐ Yes	☐ No
none of the above	☐ Yes	☐ No

15. Have you had any previous treatment for this condition? (check all that apply)

- ☐ none
- ☐ medication (oral)
- ☐ chiropractic
- ☐ naturopathic
- ☐ massage
- ☐ dental
- ☐ acupuncture
- ☐ physical therapy
- ☐ exercise
- ☐ biofeedback
- ☐ spinal injection
- ☐ prolotherapy
- ☐ traction
- ☐ TENS unit
- ☐ other _____

16. Have you had any of the following tests?

- ☐ None
- ☐ x-rays
- ☐ CT scan
- ☐ MRI
- ☐ Arthrogram
- ☐ Stress X-ray Test (Telos)
- ☐ bone scan
- ☐ NCS
- ☐ Fluoroscope
- ☐ Vestibular
- ☐ other _____

Test Results:_____

_____

MEDICATION

Please list any prescription medications you are currently taking *(pain pills, injections and/or skin patches, etc.):*

_____

_____

Prescribing MD:_____ Phone:_____

Are you currently taking any of the following over-the-counter medications?

- ☐ aspirin
- ☐ Tylenol
- ☐ corticosteriods
- ☐ antihistamines
- ☐ Advil/Motrin/Ibuprofen
- ☐ vitamins/supplements

Dosage/frequency_____

WORK HISTORY

Occupation

- ☐ employed full time
- ☐ employed part time
- ☐ self employed
- ☐ homemaker
- ☐ student
- ☐ retired
- ☐ unemployed
- ☐ other _____

Physical activities at work (check all that apply)

- ☐ sitting
- ☐ standing
- ☐ phone use
- ☐ repetitive lifting
- ☐ heavy lifting
- ☐ computer use
- ☐ heavy equipment operation
- ☐ driving
- ☐ other

Are you currently receiving or seeking disability for this condition?

☐ Yes ☐ No

If not performing your normal activities at work do you plan to **return** to your previous activity level? ☐ Yes ☐ No

PREVIOUS FUNCTIONAL LEVEL

☐ **Independent in all activities**
(work, community, home, recreation)

Self Care

- ☐ Independent in all self-care activities (bathing, toileting, dressing, etc)
- ☐ Difficulty performing self-care activities
- ☐ Need assistance with self-care activities
- ☐ Difficulty performing household chores

Social

☐ Need assistance with activities in community outside of home

Hobbies:_____

LIVING SITUATION

- ☐ live alone
- ☐ live with family members/others
- ☐ live with caregiver
- ☐ home/apartment
- ☐ retirement complex (SNF/ICF)
- ☐ assisted living complex
- ☐ other _____

Setting

- ☐ stairs (railing)
- ☐ stairs (no railing)
- ☐ elevator
- ☐ no stairs
- ☐ ramp
- ☐ uneven ground
- ☐ other _____

GENERAL HEALTH

How would you rate your general health?

☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor

Do you exercise outside of normal daily activities?

- ☐ 5+ days/wk
- ☐ 3-4 days/wk
- ☐ 1-2 days/wk
- ☐ occasionally
- ☐ zero

Type of exercise _____

_____

Do you drink caffeinated beverages?

☐ No ☐ Yes How many/much per day? _____

Do you smoke?

☐ No ☐ Yes Packs of cigarettes per day _____

What is your stress level?

☐ Low ☐ Medium ☐ High

How many hours of sleep do you get each night? _____

Do you feel rested upon waking?

☐ Yes ☐ No

Are you seeing any health care providers other than the physical therapist for this current condition? (please list) _____

_____

_____

FAMILY HISTORY

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

- ☐ Heart disease
- ☐ Stroke
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Other _____
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Cancer
- ☐ Psychological condition

PAST MEDICAL HISTORY

Have you ever had/been diagnosed with any of the following conditions? (check all that apply)

- ☐ Cancer (type) _____
- ☐ Heart problems
- ☐ Pacemaker
- ☐ High blood pressure
- ☐ Stroke
- ☐ Circulation/vascular problems
- ☐ Blood disorders
- ☐ Headaches
- ☐ Head injury
- ☐ Arthritis
- ☐ Rheumatoid arthritis
- ☐ Thyroid problems
- ☐ Stomach problems
- ☐ Ulcers
- ☐ Infectious disease (i.e. hepatitis, tuberculosis, etc)
- ☐ Depression
- ☐ Kidney problems
- ☐ Diabetes
- ☐ Hernia
- ☐ Dizziness / balance
- ☐ Epilepsy/seizures
- ☐ Lung problems
- ☐ Asthma
- ☐ Allergies
- ☐ Osteoporsis
- ☐ Broken bone
- ☐ Parkinson's disease
- ☐ Multiple sclerosis
- ☐ Rheumatic fever
- ☐ Metal implants

Please list any recent/relevant past surgeries related to your current problem:

Surgery **Date**

_____

_____

_____

HOW DID YOU HEAR ABOUT CORE PHYSICAL THERAPY?

- ☐ Dex
- ☐ Newspaper Ad
- ☐ Friend/Family
- ☐ Website, address: _____
- ☐ Internet Search:
  Keywords _____ Search Engine _____
- ☐ Other _____
- ☐ Insurance Co.
- ☐ Physician
- ☐ ReDirect Guide

I have completed the above information to the best of my ability.

Patient signature: _____ Date: _____