



**PHYSICAL THERAPY SERVICES**  
**HEALTH QUESTIONNAIRE**

We would like to understand your health. Please complete this form as best you can. This is important information in a complete evaluation. This form is part of your medical record and is private. If you need help filling out this form, please ask at the front desk.

Today's Date: \_\_\_\_\_

Home Telephone: \_\_\_\_\_

Cellular Telephone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Work Telephone: \_\_\_\_\_

**Please answer the following questions:**

1. Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

2. What injury or condition brings you here today? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. When did this problem begin? \_\_\_\_\_

4. Have you received treatment for this problem?  Yes  No

5. Have you recently had any of the following tests: (If yes, check all that apply)

- |                                  |                                      |                                      |   |
|----------------------------------|--------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> X-rays  | <input type="checkbox"/> Myelogram   | <input type="checkbox"/> EMG/NCS     | <input type="checkbox"/> Doppler Study            |
| <input type="checkbox"/> CT Scan | <input type="checkbox"/> Bone Scan   | <input type="checkbox"/> Blood Tests | <input type="checkbox"/> Pulmonary Functions Test |
| <input type="checkbox"/> MRI     | <input type="checkbox"/> Stress Test | <input type="checkbox"/> EKG         | <input type="checkbox"/> Other                    |

If yes please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Have you had broken bones, surgery or been hospitalized in the past? (If yes, please list)

Reason: \_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Are you pregnant or think you might be pregnant?  Yes  No

8. Do you have any allergies?  Yes  No

Please list any allergies that you have (i.e.: medicines, latex, bee stings): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Do you smoke?  Yes  No If yes, how much? \_\_\_\_\_

Would you like information on a program to stop smoking?  Yes  No

10. Have you experienced any slips and/or falls in the the past 6 months?  Yes  No

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4





11. Do you take any medications?

Yes  No

Please list any prescription or non-prescription drugs (i.e. herbal supplements) you are presently taking:

Medicine and reason for taking	Medicine and reason for taking

12. **Have you recently had:**

**For Therapist's Use Only:**

Fever/Chills/Sweats	Yes	No
Repeated Infections	Yes	No
Recent Weight Gain/Loss	Yes	No
Nausea/Vomiting	Yes	No
Numbness/Tingling	Yes	No
Weakness in your Arms/Legs	Yes	No
Chest Pain/Heart Palpitations	Yes	No
Pacemaker/Defibrillator	Yes	No
Shortness of Breath/Cough	Yes	No
Dizziness or Loss of Consciousness	Yes	No
Chicken Pox	Yes	No
Pelvic Inflammatory Disease	Yes	No
Trouble with your period	Yes	No
Bowel/Bladder Problems	Yes	No

13. **Have you been diagnosed with:**

**For Therapist's Use Only:**

High Blood Pressure/Heart Problems	Yes	No
Lung Problems/Tuberculosis	Yes	No
Infectious Diseases (ex. HIV, Hepatitis, MRSA)	Yes	No
Cancer	Yes	No
Kidney/ Liver Problems	Yes	No
Arthritis/Osteoporosis	Yes	No
Circulatory/Vascular Problems	Yes	No
Head Injury	Yes	No
Neurological Problems	Yes	No
Thyroid Problems	Yes	No
Seizures	Yes	No
Visual Problems	Yes	No
Hearing Problems	Yes	No
Diabetes	Yes	No

14. Do you:

- a. Have difficulty sleeping?  Yes  No
- b. Feel unsafe or afraid in your home?  Yes  No
- c. Avoid activities or people that remind you of your accident or injury?  Yes  No
- d. During the past month have you often been bothered by feeling down, depressed or hopeless?  Yes  No
- e. During the past month have you often been bothered by little interest or pleasure in doing things?  Yes  No

15. How do you learn best?  Demonstration  Visual  Written  Combination

16. What are your goals for physical therapy? \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4