Patient Questionnaire
Health History

Name:_____

Height_____Weight_____

HISTORY OF PRESENT CONDITION

Treatment side: ☐ N/A ☐ Left ☐ Right

Surgery performed?: ☐ Yes ☐ No

Surgery Date(s):_____

Surgery Type(s):_____

Hospitalization?: ☐ Yes ☐ No

Dates of Hospitalization:_____

Symptoms: _____

_____

Primary Concerns:_____

_____

PREVIOUS FUNCTIONAL LEVEL

☐ **Independent in all activities**
☐ Able to participate in recreational activities

Hobbies: _____
☐ Assisted with **self-care**
(hygiene, health-care, dressing, toileting)
☐ Assisted with **activities of daily life**
(shopping, house chores, transportation)
☐ Difficulty **changing or maintaining a body position**
☐ Transfers (lying to sitting; sit to stand)
☐ Standing, sitting, kneeling, squatting
☐ Assisted with **walking/moving around**
☐ Assisted device (cane, walker, wheelchair)
☐ Assisted with **carrying, moving, handling objects**

☐ Other:_____

CURRENT FUNCTIONAL LEVEL

Due to your injury you are having difficulty with:
☐ self-care
☐ activities of daily life
☐ changing or maintaining a body position
☐ walking/moving around
☐ carrying, moving, or handling objects

☐ Other:_____

SLEEP

In what positions do you normally sleep?

☐ Right Side ☐ Back ☐ Propped with pillows:
☐ Left Side ☐ Front _____

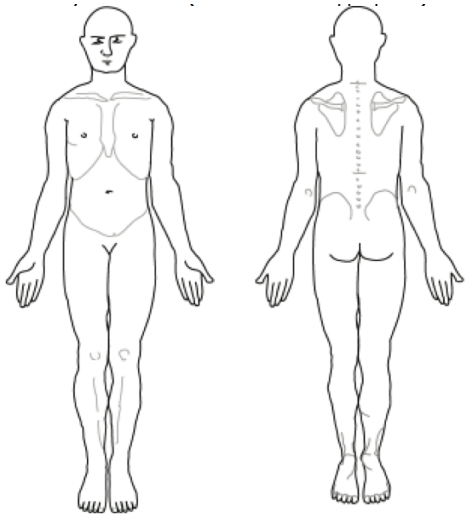
Surface: ☐ Firm ☐ Soft ☐ Other: _____

Does pain wake you or keep you up? ☐ Yes ☐ No

Hours of sleep per night:_____

PAIN

Localized areas of pain or abnormal sensation on the chart below
(shade where appropriate)



Please rate your pain level on a scale of 0-10
0 = no pain 10 = worst pain imaginable:

At worst:_____ Current:_____ At best:_____

Nature of pain/symptoms (please check all that apply):

☐ Burning ☐ Dull/Achy ☐ Sharp ☐ Intermittent
☐ Shooting ☐ Numb/Tingling ☐ Throbbing ☐ Constant

Worse with: ☐ AM ☐ Standing ☐ Stairs-Up
☐ PM ☐ Walking ☐ Stairs-Down

Other:_____

Better with: ☐ AM ☐ Standing ☐ Stairs-Up
☐ PM ☐ Walking ☐ Stairs-Down

Other:_____

Have you had similar symptoms in the past? ☐ Yes ☐ No

Number of Episodes: _____

Year of First Episode:_____

Previous treatment for similar symptoms: _____

_____

How would you rate your general health? ☐ Excellent ☐ Fair ☐ Good ☐ Poor

Do you smoke / use tobacco? ☐ Yes ☐ No
Type/Amount:_____

Have you had any recent falls? ☐ Yes ☐ No
How many?:_____

Name:_____

Patient Questionnaire
Health History

BIG SKY Physical Therapy

WORK HISTORY

Occupation:_____

- ☐ employed full time
- ☐ employed part time
- ☐ out of work
- ☐ Other:_____
- ☑ light-duty
- ☐ transitional duty
- ☐ homemaker
- ☐ not working

Duty Level:
- ☐ light
- ☐ medium
- ☐ heavy
- ☐ very-heavy

Physical activities at work:
- ☐ sitting
- ☐ standing
- ☐ driving
- ☐ Other: _____
- ☐ computer use
- ☐ phone use
- ☐ heavy equipment use

GENERAL MEDICAL HISTORY

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

☐ **No known significant past medical history**

- ☐ Osteoarthritis
- ☐ Cardiovascular Disease
- ☐ High Blood Pressure
- ☐ Blood Clots
- ☐ Asthma
- ☐ Diabetes Mellitus Type 1/ Type 2
- ☐ Latex Allergy
- ☐ Allergies:_____
- ☐ Cancer Type:_____ Dates:_____
- ☐ Current Infection
- ☐ Immunosuppression
- ☐ Osteoporosis
- ☐ Fracture or Suspected Fracture:_____
- ☐ Cauda Equina Syndrome
- ☐ Unexplained Weight Loss
- ☐ Other/Describe:_____

SURGICAL / TREATMENT HISTORY

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

☐ No recent or relevant past surgeries or treatments

Surgery / Treatment Date

_____

_____

_____

DIAGNOSTIC TESTS

Have you had any of the following tests?

- ☐ none
- ☐ x-rays
- ☐ CT Scan
- ☐ MRI
- ☐ Arthrogram
- ☐ Bone Scan
- ☐ Fluroscope
- ☐ Vestibular

☐ Other:_____

☐ Test Results:_____

_____

MEDICATION

Please list any prescription medications you are currently taking (pills, injections, skin patches, inhalers, etc.)

_____

_____

_____

_____

_____

Prescribing MD(s): Phone:

_____

_____

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

- ☐ aspirin
- ☐ Tylenol
- ☐ Advil / Motrin / Ibuprofen
- ☐ corticosteroids
- ☐ antihistamines
- ☐ vitamins/mineral supplements:

_____

_____

_____

☐ Other:_____

_____

GOALS

What are your goals for physical therapy? Please be as specific as possible:

_____

_____

_____

_____

Patient Signature: Date:

_____

Therapist Signature: Date:

_____