PRN Physical & Occupational Therapy Network, PLLC

"There when you need us"

PATIENT QUESTIONNAIRE / HEALTH HISTORY

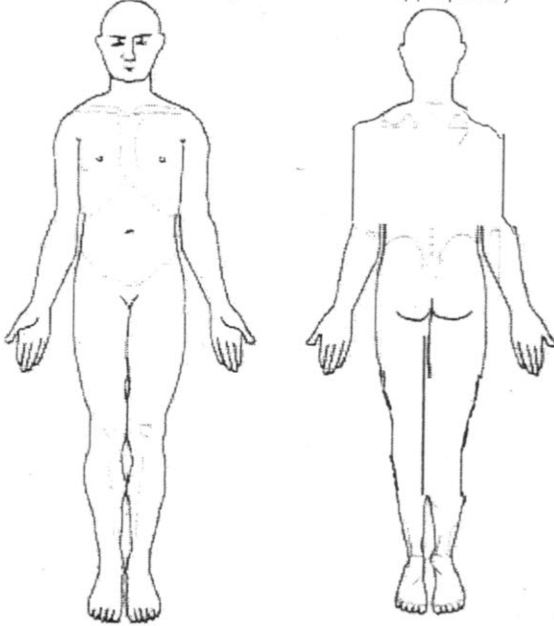
NAME: ____________________ DATE: __________

To insure you receive a complete and thorough evaluation. Please provide us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.

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)



2. When did your symptoms begin? (Please indicate a specific date if possible) __________

3. Was the onset of this episode gradual or sudden? (Check one)
__ Gradual __ sudden

4. Which of the following best describes how your injury occurred? (if your condition is post-surgical please indicate as Per original injury)

__ lifting
__ a MVA (car accident __ a fall
__ overuse (cumulative trauma) __ trauma
__ degenerative process
__ during recreation/sports __ running
__ a blow to the face
__ being hit by a ball
__ a dental appointment
__ throwing
__ an incident at work
__ unknown
__ other _______

5. Since onset, are your symptoms getting: (Circle one) better worse not changing

6. Have you had similar symptoms in the past? __ Yes __ No More than one episode? __ Yes (2) __ 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 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. What position do you sleep? (Check all that apply)
__ right side __ back __ back, sides, stomach
__ left side __ chair/recliner __ other _______
__ stomach

12. Since the onset of your current symptoms have you had:
__ any difficulty with control of bowel or bladder function
__ fever/Chills __ numbness
__ any numbness in the genital or anal area
__ any dizziness or fainting attack
__ weakness __ night pain/sweats
__ unexplained weight change
__ malaise (vague feeling of bodily discomfort)
__ problems with vision/hearing
__ none of the above

13. What aggravates your symptoms? (Check all that apply)
__ sitting
__ going to/rising from sitting
__ lying down
__ walking
__ up/down stairs
__ reaching overhead
__ reaching in front of body
__ reaching behind back
__ reaching across body
__ talking, chewing, yawning,
__ swallowing
__ recreation/sports
__ repetitive activities including _______
__ household activities including _______
__ standing
__ squatting
__ sleeping
__ coughing/sneezing
__ taking a deep breath
__ looking up overhead
__ stress
__ sustained bending
other ____________________

14. What relieves your symptoms? (Check all that apply)

__ sitting __ rest __ massage
__ heat __ standing __ medication
__ cold __ walking __ nothing
__ stretching __ exercise __ other _______
__ wearing a splint/orthosis __ lying down _______

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

__ none
__ medication (oral)
__ joint manipulation
__ exercise
__ massage therapy
__ traction
__ bracing/taping
__ injection into the spine
__ injection into the skin/muscles
__ physical therapy
__ hypnosis
_ biofeedback
__ TENS unit
__ acupuncture
__ bed rest
__ overnight
__ hospitalization
__ casting
__ other

16. Have you had any of the following tests?

__ none
__ x-rays
__ CT Scan
__ MRI
__ Arthrogram
__ Stress
__ Bone Scan
__ NCS
__ Fluoroscope
__ Vestibular
__ other______________
__ (Telos)

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
___corticosteroids
__ antihistamines
__ vitamins/mineral supplements
__Advil/Motrin/buprofen
__ other______________

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
__other______________

Setting

__ stairs (railing)
__ stairs
__ ramp
__ no stairs
___ elevator
__uneven ground
__ other______________

GENERAL HEALTH

How would you rate your general health?

Excellent Average Poor
Good Fair

Do you exercise outside of normal daily activities?

5+ days/wk. 1-2 days/wk. Zero

3-4 days/wk. Exercise, occasionally ecreation Sports/R consisting of ______

____

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

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

____

PAST MEDICAL HISTORY

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

___Cancer (type)____________
Depression
__ Stroke
__ Kidney problem
__ Thyroid problem
__ Diabetes
__ Multiple sclerosis
__ Arthritis
__ Head injury
__Stomach problems
__ Broken bone
__Infectious Diseases
__ Circulation/vascular problems
__ Other
__ Heart problems
__ High blood pressure
__ Lung problems
__ Blood disorders
__ Epilepsy/seizures
__ Allergies
__ Rheumatoid arthritis
__ Osteoporosis

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 ___ computer use ___ standing ___ heavy equipment
___ repetitive lifting ___ driving ___ heavy lifting
___ phone use
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

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

SURGERY	DATE

FAMILY HISTORY

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

___ Diabetes
___ Heart disease
___ High blood pressure
___ Stroke
___ Other____________________
___ Cancer
___ Arthritis
___ Osteoporosis
___ Psychological condition