Health Questionnaire

Name: _____ Date of Birth: _____

Primary Care Physician: _____ Physician who referred you:_____

Diagnosis/Condition requiring PT services: _____

- ❑ Motor Vehicle Accident Date_____
- ❑ Work-related Date_____
- ❑ Surgery Date_____
- ❑ Other (please explain)_____How long has this condition existed? _____

Has this condition changed your ability to: Explain limitations:

- ❑ Perform routine activities at home
- ❑ Perform routine activities at work
- ❑ Carry out personal hygiene/care
- ❑ Communicate in writing/phone

Occupation: _____ I am currently working: ___Full-time ___Part-time ___None

Please list any work restrictions: _____ ___Disabled

Activities/Sports: _____

My pain level is usually: 0 1 2 3 4 5 6 7 8 9 10

No pain Extreme pain (going to hospital)

I have had previous therapy:

- ❑ Physical Therapy For: _____ Date: _____ Results: _____
- ❑ Occupational Therapy For: _____ Date: _____ Results: _____
- ❑ Other therapies (chiropractic, acupuncture, massage, etc.)_____

Past Surgeries: _____

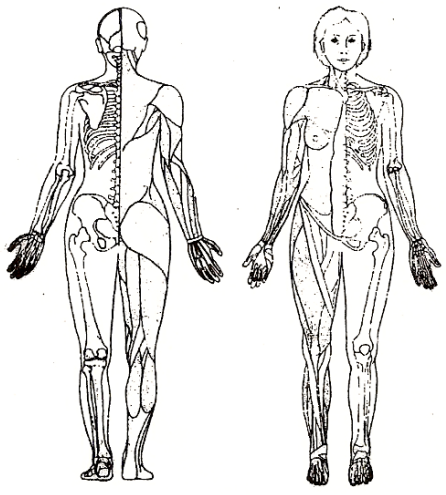
Medications currently taking: _____

Do you now or have you ever had any of the following conditions:

- ❑ Allergies
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Blood disorder
- ❑ Cancer _____
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Immuno-supressed (HIV/AIDS)
- ❑ Migraine headaches
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Shortness of Breath
- ❑ Significant hearing/vision changes
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Ulcers/Stomach pain
- ❑ Unexplained muscle fatigue
- ❑ Unusual fatigue
- ❑ Other _____

- ❑ Do you smoke?
- ❑ If female, are you pregnant?
  Due date: _____

Please draw your pain areas:



Please list your goals for therapy:

_____

_____

_____

Patient Signature: _____Date: _____

Therapist Signature: _____