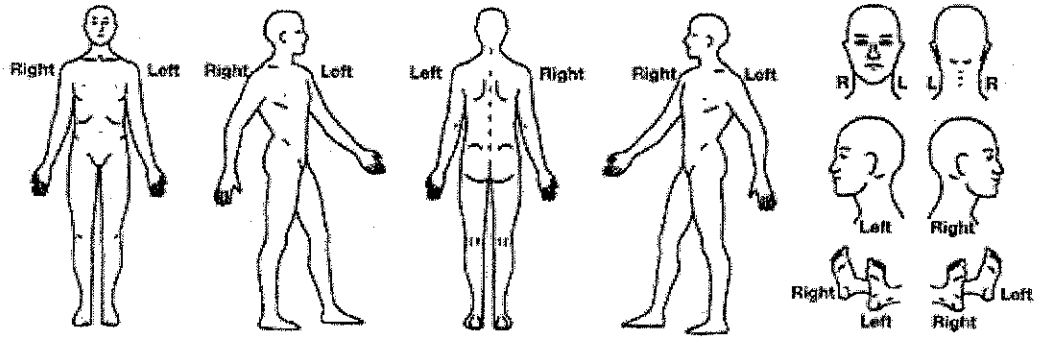
Patient Questionnaire

Name: _____ **Age:** _____

Key: Numbness: ------, Pins and Needles: ooooooo, Burning: ^^^^^^, Aching: xxxxxx, and Stabbing: ••••••



Goals of Therapy: _____

How did you hear about us:
☐ Doctor ☐ Family/Friend Referral ☐ Prior Patient ☐ Location ☐ Internet

Have you had other PT services in the past year (please circle): Yes or No **Where:** _____

How would you report your overall health to be (please circle one): Very Good Good Fair Poor

Next Referring MD Appointment: ____/____/____

Check which apply to your symptoms:
____ Work Related Injury
____ Motor Vehicle Accident
____ Athletic/Recreational Injury
____ Injury related to Lifting
____ Unknown Cause
____ Reoccurrence of previous Injury
____ Injury related to Falling
____ Other: _____

DATE OF INJURY: ____/____/____

Current Occupation: _____

Working ☐Yes ☐No
If yes (check one):
____ Full-time with No Restrictions
____ Full-time with Restrictions
____ Part-time with No Restrictions
____ Part-time with Restrictions

If no (check one):
____ Disabled
____ Retired
____ Student
____ Homemaker

Past Medical History (check any that apply past or present)
____ Osteoarthritis (boney/joint arthritis)
____ Rheumatoid Arthritis
____ Diabetes (Type ☐I or ☐II)
____ High Blood Pressure
____ Lupus
____ Thyroid (☐hyper or ☐hypo)
____ Depression
____ Anxiety
____ Sexual Dysfunctions
____ Urine Leakage
____ Bowel/Bladder Abnormalities
____ Fibromyalgia
____ Multiple Sclerosis
____ Chest Pain/angina
____ Heart Disease
____ Heart Attack (Date:_____)
____ Pacemaker
____ Headaches
____ Cancer/Tumor
____ Osteoporosis/penia
____ Recent Fractures
____ Hypoglycemia
____ Liver/Gallbladder Problems
____ Pregnant
____ Asthma
____ Stroke/CVA
____ TIA
____ Seizures/Epilepsy
____ Hernia
____ Dizziness/Fainting
____ Nausea/Vomiting
____ Ringing in Ears
____ HIV
____ Hepatitis (Type ____)
____ Allergies - list: _____
____ Metal Implants – list: _____

Surgeries: _____

Medications: _____

Is there anything else we should know about: _____