

PTSIR

PHYSICAL THERAPY AND SPORTS INJURY REHABILITATION

Patient History Questionnaire

Patient: _____

Your therapist will discuss your responses with you during the evaluation. Thank you for completing this information.

PERSONAL INFORMATION

I am currently: Employed Employed with restrictions On medical leave Not Employed

Interests/hobbies are: _____

Best way to reach me. Phone Email (address _____)

Is there anyone who can assist you with doing home exercises or activities if needed? Yes No

Will you have any problems attending therapy sessions? No Yes - If yes, please describe:

Next scheduled Dr. appointment Date _____ Physician _____

Date _____ Physician _____

KEY QUESTIONS ABOUT YOUR CONDITION

1. What is your MAIN complaint? _____

2. Please describe how you were injured or gradual onset of illness _____

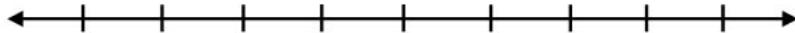
3. Date of Injury or Illness _____

4. Please mark your level of pain with an X along the following lines:

What is your pain at rest?

No Pain

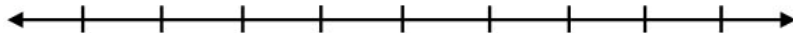
Worst Pain
Imaginable



What is your pain with activity?

No Pain

Worst Pain
Imaginable



5. Is your pain: _____ Increasing
_____ Decreasing
_____ Staying the same
_____ Occasional
_____ Constant

(Check all that apply)

6. What aggravates your pain?

7. What decreases your pain?

GENERAL HEALTH

8. Activity Level: Low Medium High

9. Prior to your injury or illness, what activities could you do that you are unable to do now?

10. Are you aware of your diagnosis? Yes No

Are you aware of your prognosis (prediction of recovery)? Yes No

11. Have you fallen in the last year? Yes No

For Office Use Only

Blood Pressure _____

Heart Rate _____

3-08

GENERAL HEALTH (cont)

12. Check All That Apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Cancer: <input type="checkbox"/> In remission | <input type="checkbox"/> Stomach Disorders | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Tingling or Numbness |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Back Injury | <input type="checkbox"/> Fracture |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Visual Problems | <input type="checkbox"/> Contagious Disease |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Skin Disease | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Chronic Back Pain | <input type="checkbox"/> Osteoporosis | |

I currently do not have any of the above health conditions

13. Uncontrolled leakage of urine? Yes No
14. Loss of bowel control? Yes No
15. Is there any chance you might be pregnant? Yes No
16. Do you smoke? Yes No
17. Do you drink alcohol? Yes No
18. Are you on a special diet? Yes No

19. List current conditions and medication you are taking: (I have attached a list)

_____ / _____	_____ / _____
_____ / _____	_____ / _____
_____ / _____	_____ / _____

20. List prior surgeries or hospitalizations

_____	Date _____	_____	Date _____
_____	Date _____	_____	Date _____

21. For patients 12 years or younger, is immunization/vaccination status current? Yes No

PERSONAL GOALS FOR THERAPY

22. What do you WANT TO achieve from having therapy? Check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Improve home activities | <input type="checkbox"/> Improve mobility/walking activities |
| <input type="checkbox"/> Improve leisure/sports activities | <input type="checkbox"/> Decrease or eliminate pain/discomfort |
| <input type="checkbox"/> Improve self care activities | <input type="checkbox"/> Return to work: <input type="checkbox"/> Current job <input type="checkbox"/> Other job |

23. Please include any additional information you feel would help us provide your care.

(ie. What you think would help, any apprehension about treatment, spiritual or cultural needs.)

To the best of my knowledge, the above information is complete and factual.

Patient Signature

Date

Use the key below to mark the areas of the body where you are having problems:

Pain Key:

OOOO Pins and needles

XXXX Burning

//////// Stabbing

==== Dull Ache

PPPP Other – describe _____

