

Health Questionnaire

Current Condition(s):

-Describe the problem for which you seek physical therapy? _____
-When did the problem begin? Month _____ Year _____

Functional Status/ Activity Level (check all that apply)

Difficulty with locomotion/ movement? bed mobility transfers walking stairs
 Difficulty with self-care? bathing dressing eating toileting
 Difficulty with home management? household chores shopping driving care of dependents
 Difficulty with community and work activities? work/school recreation/play activity

Medications:

-Do you take any prescription medications? yes no

If yes, please list: _____

Medical/Surgical History:

- Please check if you have ever had:

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Broken bones/Fractures	<input type="checkbox"/> Low blood sugar
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Seizures/epilepsy
<input type="checkbox"/> Circulation/vascular problems	<input type="checkbox"/> Head injury
<input type="checkbox"/> Heart problems	<input type="checkbox"/> Allergies
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Infectious disease (e.g. tuberculosis, hepatitis)
<input type="checkbox"/> Stroke	<input type="checkbox"/> Cancer
<input type="checkbox"/> Other _____	<input type="checkbox"/> Lung/respiratory problems

Have you ever had surgery? yes no

- If yes, please describe and include dates:

_____ Date: _____
_____ Date: _____
_____ Date: _____

Are you currently receiving home health services? yes no

For women only:

-Are you pregnant, or think you might be pregnant? yes no

-Any other gynecological or obstetrical difficulties? _____

Other Clinical Tests:

-Within the past year, have you had any of the following tests? (check all that apply)

<input type="checkbox"/> Angiogram	<input type="checkbox"/> EEG
<input type="checkbox"/> Biopsy	<input type="checkbox"/> EKG
<input type="checkbox"/> Blood tests	<input type="checkbox"/> EMG
<input type="checkbox"/> Bone Scan	<input type="checkbox"/> MRI
<input type="checkbox"/> Cat Scan	<input type="checkbox"/> Stress test
<input type="checkbox"/> Echocardiogram	<input type="checkbox"/> X-rays
<input type="checkbox"/> Other: _____	

I certify that the above information is correct to the best of my knowledge. I will not hold my physical therapist responsible for any errors or omissions that I may have made in completion of this form.

Patient's Signature: _____ Date: _____