Life's Work Physical Therapy

Patient Questionnaire

GENERAL INFORMATION

Today's date: _____

Name Code *Date of Birth*

Street Address *City* *State* *Zip*

Status: ☐ Married ☐ Single ☐ Divorced ☐ Other

Contact methods: *indicate preference by checking box*

☐ Home #: _____ ☐ Cell #: _____ Carrier: _____

☐ Work #: _____ ☐ Email: _____

Your Employer: *Employer Phone*

Emergency contact *Relationship* *Phone*

INSURANCE:

Name of subscriber if different from yours Birth date of subscriber

Would you like to receive a monthly Blog? Yes / No

PROVIDER INFORMATION

How did you hear about our clinic? _____

1. MEDICATIONS

Please list any prescription medications you are taking:

_____

Indicate any over-the-counter medications you are taking:

☐ Advil/Aleve ☐ Antihistamines
☐ Antacids ☐ Decongestants
☐ Aspirin ☐ Tylenol

Supplements/Other _____

2. ☐ Right Handed ☐ Left Handed

3. FAMILY HISTORY

Indicate (**M**)Mother (**F**)Father (**B**)Brother (**S**)Sister have had:

_____ Arthritis _____ Heart disease _____ Psychological

_____ Cancer _____ Hypertension _____ Stroke

_____ Diabetes _____ Osteoporosis _____ Other

4. GENERAL HEALTH/LIFESTYLE HABITS

My health is currently: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Life changes in the past year (new baby, job etc)? ☐ Y ☐ N

☐ I smoke: _____ packs per day _____ cigars/pipes per day

☐ I stopped smoking in _____ (year)

I average _____ (beers, glasses of wine, cocktails) per week.

Beyond normal daily activities, I do the following exercise(s):

_____

5. HEALTH CHANGES in the past year:

☐ Arm/Leg numbness/tingling ☐ Hoarseness
☐ Bladder problems/changes ☐ Joint pain or swelling
☐ Bowel problems/changes ☐ Loss of appetite
☐ Chest pain ☐ Loss of balance
☐ Coordination problem ☐ Nausea/vomiting
☐ Cough ☐ Other changes (hair loss, perspiration)
☐ Difficulty sleeping ☐ Pain at night
☐ Difficulty swallowing ☐ Pain with squatting/sitting
☐ Difficulty walking ☐ Ringing in ears
☐ Dizziness/blackouts ☐ Oral sensation changes
☐ Drop attacks ☐ Shortness of breath
☐ Fever/chills ☐ Vision problems
☐ Hearing problems ☐ Unexplained weight change
☐ Heart palpitations ☐ Other (explain):

6. PAST MEDICAL HISTORY

☐ Allergies ☐ Kidney problems
☐ Anxiety/Depression ☐ Low blood sugar
☐ Arthritis ☐ Lung problems
☐ Balance Disorders ☐ Multiple sclerosis
☐ Broken bones/fractures ☐ Muscular dystrophy
☐ Bronchitis ☐ Neurological
☐ COPD ☐ Osteoporosis
☐ Cancer ☐ Parkinson's Disease
☐ Development/growth problems ☐ Pneumonia
☐ Diabetes ☐ Motor Vehicle Accident(s)
☐ Epilepsy/seizures ☐ Repeated infections

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6. PAST MEDICAL HISTORY *(continued)*

- ☐ Fibromyalgia
- ☐ Head injury
- ☐ Headaches/migraines
- ☐ Heart problems
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Infectious disease (eg TB)
- ☐ Skin diseases
- ☐ Sleep apnea
- ☐ Sprain or strain
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Trauma
- ☐ Ulcer/stomach problems
- ☐ Whiplash

7. SURGERY

Please list where/when you've been hospitalized or had surgery.

_____

_____

8. REPRODUCTIVE HEALTH

Have you ever experienced:

- ☐ Prostate disease
- ☐ Pregnancy/delivery complications
- ☐ Current pregnancy
- ☐ Endometriosis
- ☐ Menstrual trouble
- ☐ Other OB/GYN difficulties
- ☐ Pelvic inflammatory disease

If so, please describe: _____

9. CURRENT CONDITIONS / CHIEF COMPLAINT(S)

_____

Please describe your problem

_____

Does anything make the problem(s) better?

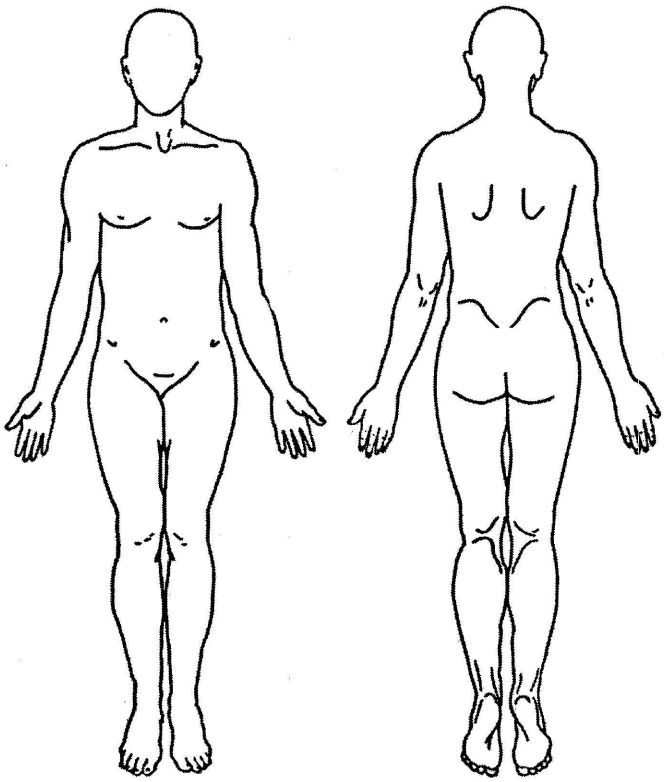
_____

Does anything make the problem(s) worse?

OTHER CLINICAL TESTS in the past year:

- ☐ Angiogram
- ☐ Arthroscopy
- ☐ Biopsy
- ☐ Blood tests
- ☐ Bone scan
- ☐ Bronchoscopy
- ☐ CT scan
- ☐ Doppler ultrasound
- ☐ Echocardiogram
- ☐ EEG
- ☐ EKG
- ☐ EMG
- ☐ Mammogram
- ☐ MRI
- ☐ Myelogram
- ☐ Nerve conduction test
- ☐ Pap smear
- ☐ Pulmonary function test
- ☐ Spinal tap
- ☐ Stool test
- ☐ Ultrasound
- ☐ Urine test
- ☐ X-rays
- ☐ Other:

Place an X to indicate where you feel pain:



10. SOCIAL HISTORY

Are there any customs/religious beliefs that may impact your care? ☐ Y ☐ N

Have you completed an advanced directive (e.g. CPR)? ☐ Y ☐ N

I am *(check all that apply)* ☐ a full time or ☐ part-time student

Job title/duties: _____

Is this a ☐ full duty or ☐ light duty position?