Integrated Physical Therapy Services

Patient History Questionnaire

Patient Name_____

Date of Birth _____/_____/_____ Weight_____ Height_____

Type of Injury/Condition _____

Injury Date_____

Previous Surgeries and Hospitalizations (type & date if applicable)_____

_____

Next scheduled appointment with Doctor (who and when)?_____

Describe previous treatment for condition_____

Have you had any images? ☐ X-ray ☐ MRI ☐ CT Scan ☐ Ultrasound

Results _____

Past/Current Medical History (please check all applicable)

☐Cancer	☐Lung Disease	☐Stomach Disorders (ulcers, etc.)
☐ Diabetes	☐Arthritis	☐Anxiety
☐Stroke/Seizures	☐High Blood Pressure	☐Heart Disease
☐Depression	☐Panic Attacks	☐Gland Problems (Thyroid)
☐Pacemaker	☐Visual Problems	☐Hearing Problems
☐Tingling or Numbness	☐HIV/AIDS	☐Hepatitis
☐Bladder/Bowel Control/Loss		

Do you have allergies (e.g. adhesives, latex, cortisone)?		☐Yes ☐No	_____
Any recent illnesses or fevers?	☐Yes	☐No	
Do you smoke?	☐Yes	☐No	How much? _____
Do you drink alcohol?	☐Yes	☐No	How much? _____
Are you having trouble sleeping?	☐Yes	☐No	
Are your pregnant?	☐Yes	☐No	
Are your currently taking medications?	☐Yes	☐No	(If yes, provide list of medications)

Pain Level:

Current:	0	1	2	3	4	5	6	7	8	9	10
At Worst:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10

Personal Goals for Therapy

What is your main complaint? _____

Rate your general activity level: Low Medium High

What do you want to achieve from having therapy? Check all that apply:

☐Improve home activities	☐Improve mobility/walk activities
☐Improve leisure/sports activities	☐Improve ability to communicate
☐Improve self-care activities	☐Decrease or eliminate pain/discomfort
☐Return to work	☐Other _____

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

SIGNATURE_____ **DATE**_____