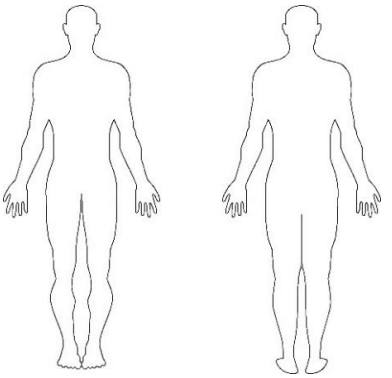
PATIENT HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ **Date of Birth:** _____ **Today's Date:** _____

MEDICARE PATIENTS ONLY: **Current Height:** _____ **ft.** _____ **in.** **Weight:** _____**lbs.**

CURRENT CONDITION FUNCTIONALITY

Please mark on the body chart below your areas of pain or abnormal sensations:



Front Back

1. When did your symptoms begin? _____
(please indicate a specific date if possible)

2. Have you had surgery in relation to this injury? Yes No
Date of surgery? ____/____/____
Type of surgery performed: _____
Name of surgeon: _____

3. Have you been hospitalized in relation to this injury?
Yes No If yes, list dates: _____

4. What are your symptoms? _____
_____

5. Was the onset of this episode gradual or sudden?
Gradual Sudden

6. Which of the following best describes how your injury occurred? (please circle)

MVA - car accident	A blow to the face
A fall	Being hit by a ball
Overuse	Surgery
Trauma	An incident at work
Degenerative process	Unknown
Sports injury/running	Other_____

7. Please describe your functional abilities **BEFORE** the condition:
- ○ Independent in all activities (home, work, recreation)
- ○ Independent in all self-care (bathe, toilet, dressing)
- ○ Mobility: walking, moving
- ○ Changing and maintaining body position
- ○ Carrying and moving objects
- ○ Other: _____

8. Please describe your abilities **AFTER** the condition occurred:
- ○ Independent in all activities (home, work, recreation)
- ○ Independent in all self-care (bathe, toilet, dressing)
- ○ Mobility: walking, moving
- ○ Changing and maintaining body position
- ○ Carrying and moving objects
- ○ Other: _____

PAIN LEVEL AND SYMPTOMS

9. What is the location of your pain? _____

Please mark your pain on the scale below:
(1 = mild, 10 = emergency room pain)

At worst:	0	1	2	3	4	5	6	7	8	9	10
Currently:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10

Since onset, are your symptoms getting: (please circle)
Better Worse Not changing

10. Nature of pain/symptoms: (please circle)

Burning	Sharp	Dull/Achy
Throbbing	Shooting	Numbness
Constant	Intermittent	Worse in AM
Worse in PM	Other: _____	

11. As the day progresses, do your symptoms:
Increase Decrease Stay the same

12. What aggravates your symptoms? (please circle)

Sitting	Taking a deep breath
Walking	Coughing/sneezing
Standing	Talking/chewing/yawning
Bending	Recreational sports
Going up stairs	Going down stairs
Lying Down	Sitting to standing
Squatting	Reaching overhead/In front of body
Looking Up	Reaching across body
Sleeping	Reaching Behind Back
Swallowing	

Repetitive activities including: _____
Household activities including: _____
Other: _____

13. What relieves your symptoms? (circle all that apply)

○ Sitting	○ Standing	○ Lying down
○ Walking	○ Exercise	○ Stretching
○ Rest	○ Heat	○ Cold
○ Massage	○ Medication	○ Wearing splint
○ Nothing	○ Other: _____	

14. Does the pain wake you at night? Yes No
If yes, is it present: 1) while lying still
2) only when changing positions
3) both

15. Do you have pain/stiffness upon getting out of bed in the morning? Yes No

16. In what position do you sleep? (circle all that apply)

Right Side	Back
Left Side	Chair/Recliner
Stomach	Back, Sides & Stomach

Continued on other side →

17. Since the onset of your current symptoms have you had:
- ○ any difficulty with control of bowel or bladder function
- ○ fever/chills
- ○ any numbness in the genital or anal area
- ○ numbness
- ○ any dizziness or fainting attacks
- ○ weakness
- ○ unexplained weight change
- ○ night pain/sweats
- ○ malaise (vague feeling of body discomfort)
- ○ problems with vision/hearing
- ○ none of the above

MEDICAL HISTORY

18. Have you had similar symptoms in the past? Yes No
More than one episode? Yes No

19. How would you rate their general health?
Excellent Good Average Fair Poor

20. Have you received home health care for this injury?
Yes No If yes, list agency: _____

21. Do you have a history of falling? Yes No

22. Have you been diagnosed with the following? (Check any that apply)
- ☐ Alzheimer's
- ☐ Cardiovascular Disease
- ☐ Cauda Equina Sydrome
- ☐ Cerebral Vascular Accident
- ☐ Current Infection
- ☐ Diabetes Mellitus Type 1
- ☐ Diabetes Mellitus Type 2
- ☐ Fibromyalgia
- ☐ Traumatic Brain Injury
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Huntington's Disease
- ☐ Immunosuppression
- ☐ Lupus
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Parkinson's
- ☐ Rheumatoid Arthritis
- ☐ Fracture/Suspected Fracture
- ☐ Other: _____

23. Please list surgical history:

Surgery Name	*Date*
_____	_____
_____	_____

24. Have you had any of the following tests? (check all that apply)
- ○ X-rays
- ○ CT scan
- ○ MRI
- ○ Arthrogram
- ○ None
- ○ NCS
- ○ Fluoroscope
- ○ Vestibular
- ○ Bone scan
- ○ Other _____

Test results: _____

25. Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?
- ○ Diabetes
- ○ Heart Disease
- ○ High Blood Pressure
- ○ Stroke
- ○ Cancer
- ○ Arthritis
- ○ Osteoporosis
- ○ Psychological condition

26. Do any of the following complicating factors apply to your treatment? (Check all that apply)
- ○ Litigation
- ○ Psycho-Social
- ○ Surgical history
- ○ Previous therapy
- ○ Multiple treatment areas
- ○ Other: _____

27. Have you had any previous treatment for this condition? (circle all that apply)
- ○ None
- ○ Medication
- ○ Joint manipulation
- ○ Exercise
- ○ Massage therapy
- ○ Traction
- ○ Bracing/taping
- ○ Injection into spine
- ○ Injection into muscle
- ○ Physical therapy
- ○ Hypnosis
- ○ Biofeedback
- ○ TENS unit
- ○ Acupuncture
- ○ Bed rest
- ○ Hospitalization
- ○ Casting
- ○ Other: _____

28. What medications are you currently taking?
- ○ Prescriptions
- ○ Over the counter
- ○ Herbals
- ○ Vitamin/Mineral Supplements
- ○ Antihistamines
- ○ Tylenol
- ○ Aspirin
- ○ Ibuprofen/Motrin
- ○ Corticosteroids
- ○ None
- ○ Other: _____

Please list all medication names and dosages: _____
_____

THERAPY GOALS AND LIFESTYLE

29. What goals do you hope to achieve by coming to therapy?
_____
_____

30. What is your occupation? _____
- ○ Employed full time
- ○ Employed part time
- ○ Self Employed
- ○ Homemaker
- ○ Student
- ○ Retired
- ○ Unemployed
- ○ Other: _____

31. Physical activities at work (circle all that apply)
- ○ Sitting
- ○ Standing
- ○ Phone Use
- ○ Computer Use
- ○ Repetitive/Heavy Lifting
- ○ Heavy Equipment
- ○ Driving
- ○ Other: _____

32. Hobbies: _____

33. What is your living situation?
- ○ Live alone
- ○ Live with family/others
- ○ Live with caregiver
- ○ Home/Apartment
- ○ Retirement Center
- ○ Assisted Living
- ○ Other: _____

34. Do you exercise outside of normal daily activities?
- ○ 5+ days/week
- ○ 3-4 days/week
- ○ 1-2 days/week
- ○ Occasionally
- ○ Not at all

35. Do you drink caffeine containing beverages? Yes No
If yes, how many per day? _____

36. Do you smoke? Yes No
If yes, how many packs per day? _____

37. What is your stress level? (Circle one)
High Medium Low

38. Are you seeing any other health care providers for this condition? (List their names): _____
_____