PATIENT'S HEALTH HISTORY **SS#**_____

First Name: _____
Last Name: _____
Address: _____
City: _____
State: _____
Date of Birth: _____
Sex: ☐ Male / ☐ Female
Are you: ☐ Right Handed ☐ Left Handed
Type of Insurance: _____
Secondary Insurance: _____
Subscriber: _____
Who referred you to this Physical Therapist?
_____

Education:
Highest Grade Completed: _____
☐ Some College/Technical School
☐ College Graduate
☐ Graduate School/Advanced Degree

Employment:
☐ Full Time
☐ Part Time
☐ Student
☐ Retired
Occupation: _____

Where do you live?
☐ Private Home
☐ Private Apartment
☐ Other _____

With whom do you live?
☐ Alone
☐ Spouse
☐ Spouse & Children
☐ Children
☐ Other _____

Does your home have:
☐ Stairs, No Railing
☐ Stairs, Railing
☐ Ramps
☐ Elevator
☐ Uneven Terrain
☐ Other Obstacles? _____

Do you use:
☐ Cane ☐ Wheelchair
☐ Walker ☐ Motorized Wheelchair
☐ Other _____

General Health:
☐ Excellent ☐ Good
☐ Fair ☐ Poor
Have you had any major life changes in the last year? (new baby, job change, death of family member, etc.)
☐ Yes ☐ No

Health Habits:
Do you exercise beyond normal daily activities and chores?
☐ Yes ☐ No
How many days ___ How many minutes ___

Smoking:
Do you currently smoke? ☐ Yes ☐ No
Number of packs per day? ___
Smoked in the past? ☐ No ☐ Yes, Year quit ___

Alcohol:
How many days per week do you drink an alcoholic beverage, on average? _____

Family History: (Indicate whether Parents, Siblings, Aunts/Uncles or Grandparents)
Heart Disease _____
Hypertension _____
Stroke _____
Diabetes _____
Cancer _____
Other _____

Have you ever completed an Advanced Directive?
☐ Yes ☐ No

Medication:
Do you take any prescription medications?
_____
_____
_____

Do you take any non-prescription medications?
☐ Advil ☐ Decongestants
☐ Antacids ☐ Herbal Supplements
☐ Ibuprofen/Naproxen ☐ Tylenol
☐ Antihistamines ☐ Other
☐ Aspirin _____

Have you ever had surgery? ☐ Yes ☐ No
If yes, please describe:

_____ When _____
_____ When _____
_____ When _____
_____ When _____

PLEASE CONTINUE QUESTIONNAIRE ON NEXT PAGE

MEDICAL HISTORY:

HEIGHT _____ WEIGHT _____

Please check all that apply:

- ☐ Allergies
- ☐ Arthritis
- ☐ Blood Disorder
- ☐ Broken Bones
- ☐ Cancer
- ☐ Circulation Problems
- ☐ Depression
- ☐ Diabetes
- ☐ Head Injury
- ☐ Heart Disease
- ☐ Infectious Disease
- ☐ Kidney Problems
- ☐ Low Blood Sugar
- ☐ Lung Problems
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Repeated Infections
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Infectious Disease
- ☐ Stomach Problems

In the past year, have you had any medical tests?

_____ Date _____

_____ Date _____

_____ Date _____

Current Limitations Due to Current Problem:

- ☐ Difficulty with Movement
- ☐ Bed Mobility
- ☐ Transfers (bed to commode, etc…)
- ☐ Walking
  - ☐ On Level Terrain
  - ☐ On Stairs
  - ☐ On Ramps
  - ☐ On Uneven Terrain
- ☐ Difficulty with Home Management
- ☐ Difficulty with Work
- ☐ Difficulty with Recreational Activity

Are you seeing anyone else for this problem?

_____

_____

Within the past year, have you had any of the following symptoms?

- ☐ Bowel Problems
- ☐ Chest Pain
- ☐ Cough
- ☐ Difficulty Sleeping
- ☐ Difficulty Swallowing
- ☐ Difficulty Walking
- ☐ Dizziness or Blackouts
- ☐ Fever/Chills/Sweats
- ☐ Headaches
- ☐ Hearing Problems
- ☐ Heart Palpitations
- ☐ Joint Pain/Swelling
- ☐ Loss of Appetite
- ☐ Loss of Balance
- ☐ Nausea/Vomiting
- ☐ Pain at Night
- ☐ Shortness of Breath
- ☐ Urinary Problems
- ☐ Vision Problems
- ☐ Weakness in Arms or Legs
- ☐ Weight Loss/Gain

When is your next scheduled Dr.'s Appointment for your current problem?

_____ /_____ /_____

Thank you for your time in answering our questionnaire. This will aid us in giving you the best care possible. If you have any questions for us, please feel free to ask.