Fort HealthCare
Therapy & Sport Center

PATIENT HISTORY QUESTIONNAIRE

Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Date of Next Dr. Appt: _____

Occupation: _____ Leisure Activities: _____

Family Physician: _____ Referring Physician: _____

What is your chief complaint? _____

What caused your symptoms to begin? _____

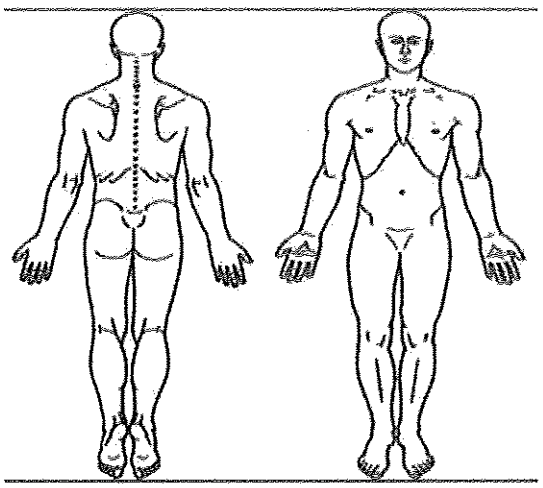
_____ Date Symptoms began: _____

Please describe your symptoms (i.e. sharp, dull, tingling, etc.): _____

_____

Indicate on the diagrams below, the area(s) or location(s) Where you are currently experiencing symptoms, using Following key:

PPPPP = pins and needles SSS = stabbing
XXXXX = burning ZZZ = deep ache



Please indicate below the intensity of your symptoms. (Circle the appropriate number.)

(0 = no symptoms, 10 = worst possible symptoms)

Current:

0 1 2 3 4 5 6 7 8 9 10

Best:

0 1 2 3 4 5 6 7 8 9 10

Worst:

0 1 2 3 4 5 6 7 8 9 10

How often do you experience your symptoms (per day)?

____ Constantly (24 hrs) ___ Frequently (16-23 hrs)

____Occasionally (8-16 hrs) ___Intermittently (0-8 hrs)

What activity are you most limited with due to your pain or injury?

_____

0 1 2 3 4 5 6 7 8 9 10

Unable to Perform activity

Able to perform activity at the same level as before injury or problem

Please check any of the following whose care you are under:

____ Medical Doctor (MD) ____ Osteopath ____ Dentist _____ Psychiatrist/psychologist

____Physical Therapist ____ Chiropractor Other: _____

Please list any other treatments you have received for this condition: _____

_____

Please check if you, or a member of your family, have or has ever had any of the following:

You	Family		You	Family		You	Family	
___	___	Heart Problems	___	___	thyroid disorders	___	___	Radiculitis
___	___	High Blood Pressure	___	___	Sciatica	___	___	Vertigo
___	___	Circulatory Problems	___	___	Deep vein thrombosis	___	___	Dementia
___	___	Asthma	___	___	Raynaud's	___	___	Seizures
___	___	Emphysema/bronchitis	___	___	Multiple Sclerosis	___	___	Hepatitis
___	___	COPD	___	___	Depression	___	___	Tuberculosis
___	___	Rheumatoid Arthritis	___	___	Obesity	___	___	Anemia
___	___	Other arthritic cond.	___	___	Stroke	___	___	Kidney disease
___	___	Diabetes	___	___	Chemical dependency			
___	___	Chronic ulcer	___	___	Difficulty walking due a joint disorder			
___	___	Osteoporosis	___	___	Other: _____			

Please list any surgeries or other conditions you have experienced requiring hospitalization, including approximate date.

_____

_____

Please list any medications and/or supplements/herbs you are currently taking (prescription and over-the-counter).

_____

_____

Do you smoke or use nicotine products? YES NO How much per day?_____

Do you drink alcohol? YES NO # of days per week _____ # drinks in average sitting ____

Are you latex sensitive? YES NO

Have you declared the Advanced Clinical Directive of Do Not Resuscitate(DNR)? YES NO

During the past month have you been feeling down, depressed, or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Are you afraid physical activity will increase your pain or be harmful to you? YES NO

Have you recently noted any of the following? (Please check all that apply.)

____ weight loss/gain	____ unintentionally dropping objects	____ vision changes
____ nausea/vomiting	____ fever/chills/sweats	____ hearing disturbances
____ dizziness/lightheadedness	____ numbness or tingling	____blackouts
____ fatigue	____ balance disturbances	____ difficulty swallowing
____ hearing disturbances	____ difficulty sleeping/pain at night	____ pregnancy
____ difficulty with communication	____ incontinence/difficulty voiding	____ weakness

Please list any other concerns you may have: _____

_____