SUMMIT REHABILITATION ASSOCIATES

Patient Questionnaire/Health History

Name: _____ Date: _____

History of Present Condition

1. What are your symptoms/chief complaints?

_____

_____

_____

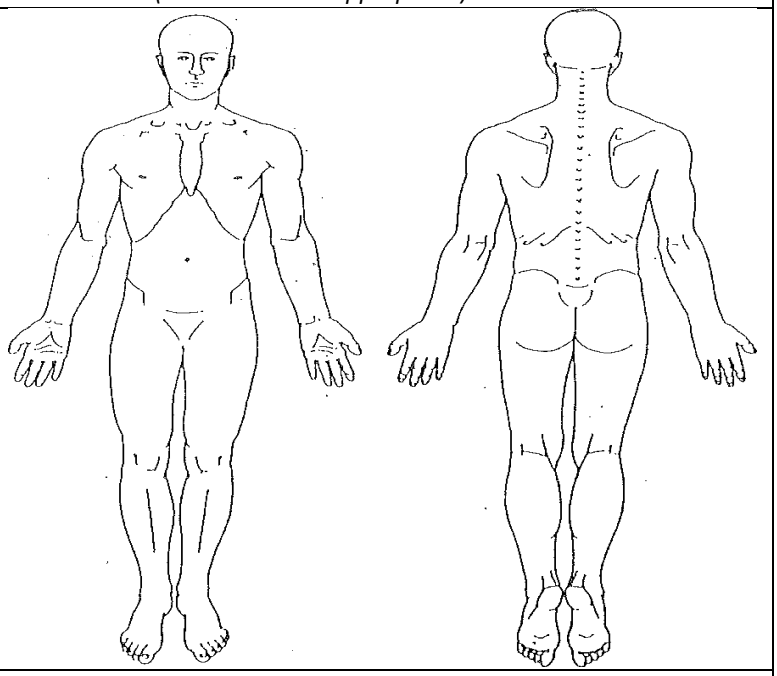
2. When did your symptoms begin? *(Please indicate a specific date or surgery date if possible)*: _____

3. Please indicate the worst your pain has been in the last 24 hours on the scale below:

(0 being no pain at all, 10 being the worst pain imaginable)

Now: _____ Worst: _____ Best: _____

Localize areas of **pain** or **abnormal** sensation on the body chart below *(shade in where appropriate)*



4. Nature of pain/symptoms *(check all that apply)*

- ☐ Sharp
- ☐ Dull
- ☐ Throbbing
- ☐ Numbness
- ☐ Aching
- ☐ Occasional
- ☐ Constant
- ☐ Other: _____

_____

5. Which of the following **best describes** how your injury occurred?
(If *your condition is post-surgical please indicate per original injury)*

☐ Lifting	☐ A MVA (Car Accident)	☐ Unknown
☐ Trauma	☐ During Recreation/Sports	☐ Other: _____
☐ An incident at work	☐ A Fall	_____
☐ Degenerative Process	☐ Overuse (cumulative trauma)	_____

6. Since onset, are your symptoms getting: *(check one)* ☐ Better ☐ Worse ☐ Not Changing

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

8. Please list any recent/relevant past surgeries related to current problem.

_____

_____

9. In what position do you sleep? *(check one)* ☐ Back ☐ Sides ☐ Stomach

Previous Functional Level

10. ☐ Independent in all activities (work, community, home, recreation)

Self-Care	☐ Independent in all self-care activities (i.e. bathing, dressing) ☐ Difficulty performing self-care activities ☐ Need assistance with self-care activities ☐ Difficulty Performing household chores
Social	☐ Need assistance with activities in community outside of home
Hobbies	_____

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11. 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 bodily discomfort)
- ☐ Problems with vision/hearing
- ☐ Other: _____

12. What aggravates your symptoms? *(check all that apply)*

- ☐ Sitting
- ☐ Going to/rising from sitting
- ☐ Lying down
- ☐ Walking
- ☐ Up/down stairs
- ☐ Reaching overhead
- ☐ Reaching in front of body
- ☐ Reaching behind back
- ☐ Reaching across body
- ☐ Talking, Chewing Yawning, all
- ☐ Urinating/Bowel Movement
- ☐ Standing
- ☐ Squatting
- ☐ Sleeping
- ☐ Coughing/sneezing
- ☐ Taking a deep breath
- ☐ Looking up overhead
- ☐ Swallowing
- ☐ Stress
- ☐ Sustained bending
- ☐ Recreational/sports including: _____
- ☐ Repetitive activities including: _____
- ☐ Household activities including: _____
- ☐ Other: _____

13. As the day progresses, do your symptoms: (*check one)*

☐ Increase ☐ Decrease ☐ Stay the same

14. Does the pain wake you up at night? ☐ Yes ☐ No

If 'yes', is it present:

- ☐ while lying still
- ☐ both
- ☐ only when changing positions

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

16. What improves your symptoms? *(check all that apply)*

- ☐ Sitting
- ☐ Heat
- ☐ Cold
- ☐ Stretching
- ☐ Rest
- ☐ Standing
- ☐ Walking
- ☐ Exercise
- ☐ Lying down
- ☐ Massage
- ☐ Medication
- ☐ Wearing a splint/orthosis
- ☐ Nothing
- ☐ Other: _____

17. Have you had any previous treatment for this condition?

- ☐ None
- ☐ Physical Therapy
- ☐ Massage Therapy
- ☐ Chiropractic
- ☐ Traction
- ☐ Medication
- ☐ Injection
- ☐ Biofeedback
- ☐ TENS Unit
- ☐ Acupuncture
- ☐ Bed rest
- ☐ Hospitalization
- ☐ Bracing/Taping/Casting
- ☐ Other: _____

18. Have you had any of the following tests?

- ☐ None
- ☐ X-Rays
- ☐ CT Scan
- ☐ MRI
- ☐ Stress X-Ray Test
- ☐ Arthrogram
- ☐ Nerve Conduction Study
- ☐ Bone Scan
- ☐ EMG
- ☐ Other: _____

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19. Have you ever had/been diagnosed with any of the following conditions *(check all that apply)*

☐ Cancer (type): _____	☐ Head injury	☐ Epilepsy/seizures
☐ Depression	☐ Stomach problems	☐ Allergies
☐ Stroke	☐ Infectious diseases	☐ Rheumatoid arthritis
☐ Kidney problems	☐ Heart problems	☐ Osteoporosis
☐ Thyroid problems	☐ High blood pressure	☐ Broken bone
☐ Diabetes	☐ Lung problems	☐ Circulation/vascular problems
☐ Multiple sclerosis	☐ Blood disorders	☐ Other: _____
☐ Arthritis		_____

Living Situation

20. Current living situation

☐ Live alone	☐ Home/Apartment	☐ Assisted Living Complex
☐ Live w/ family members/others	☐ Retirement Complex	☐ Other: _____

Work History

21. Occupation: _____

☐ Employed full time	☐ Homemaker	☐ Unemployed
☐ Employed part time	☐ Student	☐ Other: _____
☐ Self employed	☐ Retired	_____

22. Physical activities at work *(check all that apply)*

☐ Sitting	☐ Repetitive lifting	☐ Heavy equipment operation
☐ Standing	☐ Heavy lifting	☐ Driving
☐ Phone use	☐ Computer use	☐ Other: _____

23. If not performing your normal activities at work do you plan to RETURN to your previous activity level? ☐ Yes ☐ No

General Health

24. How would you rate your general health?

☐ Excellent	☐ Average	☐ Poor
☐ Good	☐ Fair	

25. Do you exercise outside of normal daily activities?

☐ 5+ days/wk	☐ 1-2 days/wk	☐ Zero
☐ 3-4 days/wk	☐ Occasionally	

26. Exercise, Sports/Recreation consisting of: _____

27. Do you smoke? ☐ Yes ☐ No | Packs per day: _____

Medication:

28. Please list any medications you are currently taking:

_____	_____
_____	_____
_____	_____
_____	_____

29. Are you currently taking any of the following over the counter medications?

☐ Aspirin	☐ Ibuprofen	☐ Vitamins/Mineral Supplements
☐ Tylenol	☐ Advil/Motrin	☐ Other: _____

30. Are you seeing any health care providers other than the physical therapist for this current condition?

☐ Surgeon	☐ Chiropractor	☐ Other: _____

Goals for Therapy Services:

_____

_____

_____