SUMMIT
REHABILITATION ASSOCIATES

Patient Questionnaire/Health History

Name: _____ Date: _____

History of Present Condition

1. What are your symptoms/chief complaints?

_____

_____

2. Have you received PT, OT and/or Massage Therapy, or home health care this year? ☐ Yes ☐ No

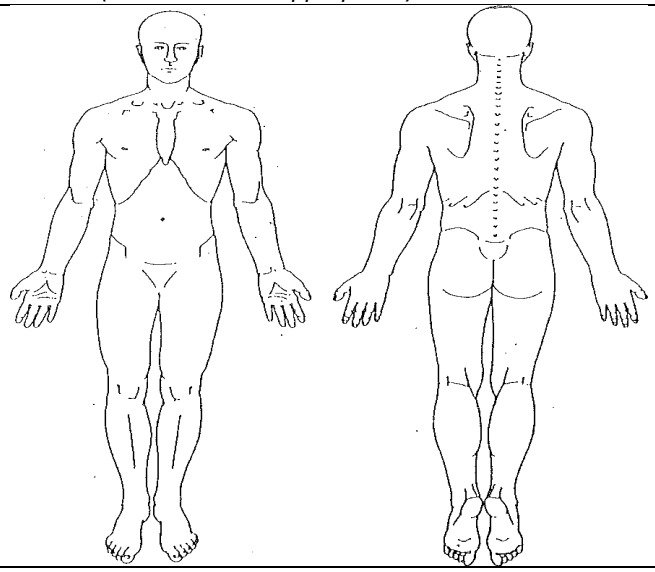
3. When did your symptoms begin? *(Please indicate a specific date or surgery date if possible)*: _____

4. 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)

Best: _____ Worst: _____ Now: _____

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



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

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

_____

6. 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)	_____

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

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

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

_____

_____

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

Previous Functional Level

11. ☐ 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	☐ _____

12. Since the onset of your current symptoms have you had:

☐ Any difficulty with control of bowel or bladder function ☐ Unexplained weight change

SUMMIT
REHABILITATION ASSOCIATES

Patient Questionnaire/Health History

☐ Fever/Chills ☐ Any numbness in the genital or anal area ☐ Numbness ☐ Any dizziness or fainting attacks ☐ Weakness	☐ Night pain/sweats ☐ Malaise (vague feeling of bodily discomfort) ☐ Problems with vision/hearing ☐ Other: _____

13. 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: _____

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

☐ Increase	☐ Decrease	☐ Stay the same

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

If 'yes', is it present:	☐ while lying still ☐ both ☐ only when changing positions

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

17. 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: _____

18. 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: _____

19. 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: _____

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

SUMMIT
REHABILITATION ASSOCIATES

Patient Questionnaire/Health History

☐ 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

21. Current living situation

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

Work History

22. Occupation: _____

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

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

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

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

General Health

25. How would you rate your general health?

☐ Excellent	☐ Average	☐ Poor
☐ Good	☐ Fair	

26. Do you exercise outside of normal daily activities?

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

27. Exercise, Sports/Recreation consisting of: _____

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

Medication:

29. Please list any medications you are currently taking:

_____	_____
_____	_____
_____	_____
_____	_____

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

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

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

☐ Surgeon	☐ Chiropractor	☐ Other: _____

Goals for Therapy Services:

_____

_____

_____