SUMMIT
REHABILITATION ASSOCIATES

Patient Questionnaire/Health History

Name: _____

Pronoun Preference? If yes, please specify _____

1. What are your symptoms/chief complaints?

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

Indicate your pain levels below *(0 being no pain at all, 10 being the worst pain imaginable)*

Best: _____ Worst: _____ Now: _____

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

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

4. Location of symptoms (*please describe where on your body your symptoms are located*)

5. Describe your injury/condition and how it occurred (*If your condition is post-surgical, please indicate per original injury)*

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

7. What positions/activities aggravate your symptoms?

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

- ☐ None
- ☐ Chiropractic
- ☐ Physical Therapy
- ☐ Medication
- ☐ Massage Therapy
- ☐ Injection(s)

9. Have you had any of the following tests?

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

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

- ☐ Cancer (type): _____
- ☐ Depression
- ☐ Stroke
- ☐ Kidney problems
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Multiple sclerosis
- ☐ Arthritis
- ☐ Head injury
- ☐ Blood disorders
- ☐ High blood pressure
- ☐ Stomach problems
- ☐ Lung problems
- ☐ Infectious diseases
- ☐ Heart problems
- ☐ Vertigo
- ☐ Other: _____

11. Occupation: _____

- ☐ Employed full time
- ☐ Employed part time
- ☐ Homemaker
- ☐ Student
- ☐ Self employed
- ☐ Retired

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

13. Goals for Therapy Services: