



**Integrated Physical Therapy Services**

**PATIENT HISTORY QUESTIONNAIRE**

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Type of Injury/Condition \_\_\_\_\_

Injury Date \_\_\_\_\_

Previous Surgeries and Hospitalizations  
( type & Date if applicable) \_\_\_\_\_

Next scheduled appointment with Doctor (who and when) \_\_\_\_\_

Describe previous treatment for condition \_\_\_\_\_

Have you had imaging performed:  X-ray  MRI  CT Scan  Ultrasound  
Results \_\_\_\_\_

**Past/ Current Medical History (please check any applicable)**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Cancer                      | <input type="checkbox"/> Lung Disease        | <input type="checkbox"/> Stomach Disorders (ulcers, etc.) |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Anxiety                          |
| <input type="checkbox"/> Stroke/ Seizures            | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease                    |
| <input type="checkbox"/> Depression                  | <input type="checkbox"/> Panic Attacks       | <input type="checkbox"/> Gland Problems (thyroid)         |
| <input type="checkbox"/> Pacemaker                   | <input type="checkbox"/> Visual Problems     | <input type="checkbox"/> Hearing Problems                 |
| <input type="checkbox"/> Tingling or Numbness        | <input type="checkbox"/> HIV/ AIDS           | <input type="checkbox"/> Hepatitis                        |
| <input type="checkbox"/> Bladder/ Bowel Control Loss |  |   |

Do you have allergies (eg. Adhesives, latex, cortizone) ?  yes  no \_\_\_\_\_

Any recent illness or fevers?  yes  no

Do you smoke?  yes  no How much? \_\_\_\_\_

Do you drink alcohol?  yes  no How much? \_\_\_\_\_

Are you having trouble sleeping?  yes  no

Are you pregnant?  yes  no

Are you currently taking medications?  yes  no

Please list medications \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Personal Goals for Therapy**

What is your main complaint? \_\_\_\_\_

Rate your general activity level  Low  Medium  High

What do you want to achieve from having therapy? Check all that apply

- |  |   |
|--|---|
| <input type="checkbox"/> Improve home activities           | <input type="checkbox"/> Improve mobility/ walking activities   |
| <input type="checkbox"/> Improve leisure/sports activities | <input type="checkbox"/> Improve ability to communicate         |
| <input type="checkbox"/> Improve self-care activities      | <input type="checkbox"/> Decrease or eliminate pain/ discomfort |
| <input type="checkbox"/> Return to work                    | <input type="checkbox"/> Other _____                            |

*To the best of my knowledge , the above information is complete and factual.*

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Date*