

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.

SIGNATURE _____ **DATE** _____