Connect Physical Therapy
17120 Pilkington Road
Lake Oswego, OR 97035

PATIENT HISTORY QUESTIONNAIRE

Date_____

Patient Name_____ Nickname_____
FIRST MIDDLE LAST

Your therapist will discuss your responses with you during the evaluation. Thank you for completing this information.

PERSONAL INFORMATION

I am currently: ☐Employed ☐Employed with restrictions ☐On medical leave ☐Not employed

I currently: ☐Live alone ☐Live with caregiver ☐Live with family members

Current living environment: ☐Home/apartment ☐Retirement home ☐Assisted living

Do you smoke? ☐Yes ☐No Packs per day_____ Do you drink alcohol? ☐Yes ☐No Drinks per week_____

Do you exercise? ☐Yes ☐No Type_____ Times per week_____

Interests/hobbies/exercise_____

Will you have any problems attending therapy sessions? ☐Yes ☐No

GENERAL HEALTH

Medical conditions you currently have or have had in the past (check all that apply):

☐ Allergies ☐Arthritis/Gout ☐Blood Disorder ☐Cancer ☐Circulation/Vascular Problems ☐Heart Disease

☐Depression ☐ Diabetes ☐Epilepsy/Seizures ☐Fibromyalgia ☐Head Injury ☐Hearing Problems

☐ High Cholesterol/Lipids ☐ Recent Hospitalization ☐Hypertension ☐Infectious Disease ☐Kidney Disease

☐ Liver Disease ☐Lung Disease ☐ Migraines ☐Multiple Sclerosis ☐Osteoporosis ☐Pacemaker

☐Panic Attack/Anxiety ☐Parkingson's Disease ☐Stomach Disease/Ulcer/Reflux ☐Stroke/Paralysis ☐Thyroid Disease

☐ Visual Problems ☐Surgery-Type(s)_____

If female, are you currently pregnant? ☐Yes ☐No

Are you taking any medications? ☐Yes ☐No If yes please list_____

Have you had any prior treatment for your condition (check all that apply)?

☐ Hospitalization ☐Bracing/Taping/Casting ☐Physical Therapy ☐Surgery ☐ TENS/Stimulation Unit ☐Injections

☐ Chiropractics ☐Acupuncture ☐Other_____

Are you having trouble sleeping ☐Yes ☐No Normal Hours of sleep_____hours Current Hours of Sleep_____hours

PREVIOUS FUNCTION LEVEL

Before onset of my current symptoms (or prior to injury), I was: ☐Independent in all activities ☐Dependent for all care

☐ Independent with self care only ☐Needing assistance with some activities

PERSONAL GOAL FOR THERAPY

What do you want to achieve from having therapy? ☐Reduce Pain ☐Increase Function ☐Return to Work

☐Return to usual housework/yard work ☐Sleep without waking up ☐Return to recreation,

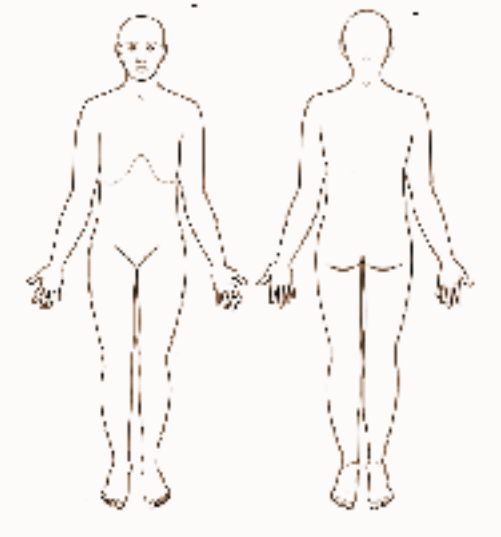
Types_____ ☐ Other _____

KEY QUESTIONS ABOUT YOUR CONDITION

What is your **MAIN** complaint?_____

_____

Darken the areas on the body where you are having problems:



Please mark your level of pain with an X on the following lines:

What is your level of pain at rest?

No Pain Worst Pain Imaginable

What is your pain with activity?

No Pain Worst Pain Imaginable

How would you describe your pain (check all that apply)?

☐ Aching ☐ Burning ☐Cramping ☐Crushing ☐Discomfort ☐Dull ☐Gnawing

☐Loss of Sensation ☐Numbness ☐Pressure ☐Sharp ☐Stabbing ☐Stinging ☐Swollen ☐Throbbing ☐Tight

☐Tingling ☐Weakness ☐Other_____

How and when did these symptoms begin?_____

_____

What makes your symptoms worse?_____

_____

What makes symptoms better?_____

_____

Since the onset of your symptoms have you had any of the following (check all that apply)?

☐Significant, unexplained weight loss ☐Atypical night pains ☐Impared bowel/bladder function ☐Pian in multiple areas

☐Dizziness/Fainting ☐Muscle weakness ☐Fever/chills ☐Numbness ☐Visual/hearing Problems