Homer Physical Therapy Patient Questionnaire

CONSENT: I understand that my diagnosis and treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered.

(Sign)_____(Date)_____

Do you have any learning barriers? Yes / No If AYes@, please list?_____ Birth Date:_____

Gender: M/F Age: _____ Smoker: Y / N Pregnant: Y/ N Occupation_____

Do you exercise at least 3 days per week? Y / N If so, what kind? _____

Date of Last Medical Checkup: _____ Past Surgical History: **LIST / DATE ON BACK OF PAGE**

Current Medications/Supplements: **LIST ON BACK OF PAGE or circle None**

Past Medical History: please circle each condition that you have been told you have (or had):

Cancer - If yes, what kind?_____When?_____
Allergies - If yes, what kind?_____
Diabetes Kidney Disease Liver Disease Poor Balance (falls) Sexual Abuse High Blood Pressure Heart Disease
Angina/Chest Pain Ulcers Domestic Violence Osteoporosis Osteoarthritis Rheumatoid Arthritis
Sexually Transmitted Disease Asthma Lung Disease Fibromyalgia
Have you had a recent illness? (Explain if yes) _____
Do you take blood thinners? Yes / No Are you allergic to latex? Yes / No Other: _____

Currently I am experiencing (circle all that apply):
Fever/Chills/Sweats Poor Balance (falls) Unexplained Weight Loss Numbness or Tingling Changes In Appetite
Difficulty Swallowing Depression Shortness of Breath Dizziness Headaches Changes in Bowel or Bladder Function
Nausea/Vomiting Increased Pain at Night Physical/Emotional Abuse Change in Hearing/Speech/Vision Loss of Coordination

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How are you able to sleep at night? Fine _____ Moderate Difficulty _____ Only with Medication _____

Does your current complaint make sleep more difficult? _____

During the past month, have you often been bothered by feeling down, depressed or hopeless? Yes / No

During the past month, have you often been bothered by little interest or pleasure in doing things? Yes / No

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What is your Main Complaint?_____
What is your Secondary Complaint? _____

When did your pain begin?_____How (gradually, suddenly)?_____

Is your pain/condition related to - (circle what applies) Non-work New Injury Pre-Operative Post-Surgical
Exacerbation of pre-existing injury Re-occurrence of Pre-existing Injury Sports

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My symptoms are currently (circle one): Getting better / About the same / Getting worse

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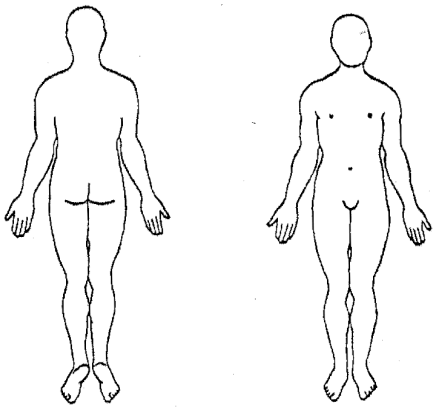
Your Physical Therapist would also appreciate knowing what other services you have, are, or are planning to utilize for this diagnosis:
Primary Physician Chiropractic OT PT Orthopedic Surgeon Neurologist Massage Acupuncture Gynecologist
Exercise Bed Rest Ice Heat Medication General Surgeon Other_____

Body Chart: Please mark the areas on the chart where you feel pain

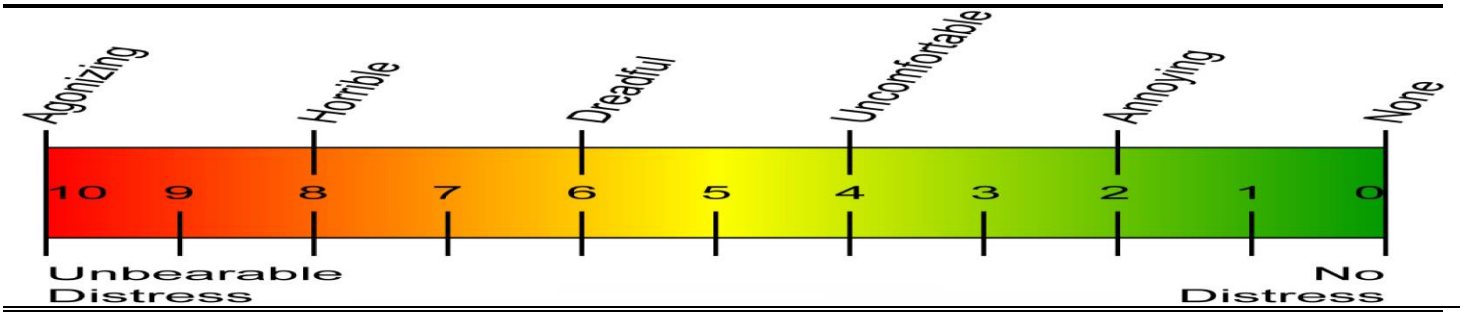


Have you had any of the following for this complaint?

X-Ray MRI CT Scans(CAT) Doppler Study Ultrasound

Other: _____

On the scale below, place a **C** over current pain level; a **W** over worst pain level; a **B** over best pain level:



On the scale below, please circle the number which best represents your level of function:

0 1 2 3 4 5 6 7 8 9 10

Cannot Do Anything Able to Do Everything

What are 3 activities you cannot perform due to pain?

1_____

2_____

3_____

Are you currently able to work? Yes No Light duty Modified duty

If you are not working, when was your last day of work: _____

What are your personal goals for therapy at this time?

1_____

2_____

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Please read carefully our policies regarding your treatment:

1. You are expected to participate in your own care. If you do not keep your scheduled appointments, accept the limitations that have been placed on you by your physical therapist and follow through with your Home Exercise Program, it could lead to a premature discharge.
2. Be honest with your therapist. In order for you to receive the best care, your therapist needs to know what you have been doing and how you feel.
3. If you are more than 15 minutes late for your appointment, it will be considered a No-Show. You will be billed accordingly.

Signature _____ Date _____