THERAPY HEALTH HISTORY QUESTIONNAIRE

Acct# _____

MR# _____

Name: _____ Date/Time: _____ Completed by: _____

WHAT BRINGS YOU TO THERAPY TODAY? Please include date of injury or onset of condition.

_____

PAIN: **If your main reason for attending therapy is pain, please answer the following question:**
In the last 48 hours, when you get your pain, where would you rank the intensity on this scale?

No Pain **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** **Worst Possible Pain**

WHAT ARE YOUR GOALS FOR THERAPY? _____

DIAGNOSTIC TESTS: Have you had any of the following tests for your current condition?
☐ X-ray ☐ MRI ☐ CTscan ☐ EMG ☐ Lab work
☐ Other _____ Site/Date/Results: _____ ☐ None

PREVIOUS TREATMENT: Have you received any of the following treatment for this condition?
☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Chiropractic
☐ Podiatric ☐ Injections ☐ Massage ☐ Other _____ ☐ None
Was the treatment helpful? _____

SURGICAL HISTORY: Please list operations you have had in the past and dates if possible:

_____

_____

OCCUPATION: _____ **Are you currently working?** ☐ Yes Hours/week _____ ☐ No
☐ Retired ☐ Restricted Duty _____

My job requirements include:
☐ Prolonged standing ☐ Use of equipment ☐ Prolonged sitting: computer/desk work/assembly line
☐ Driving ☐ Prolonged walking ☐ Lifting, bending, twisting, turning

SOCIAL HISTORY/LIVING ENVIRONMENT:
Do you live: ☐ Alone ☐ With spouse/partner ☐ With family ☐ With roommate
Do you live in a: ☐ Home ☐ Apartment ☐ Other _____
How many stories: _____ How many steps: _____
Assistive devices/equipment (walkers/cane/etc): _____

Do you smoke? ☐ No ☐ Yes: _____packs/day
Do you drink alcohol? ☐ No ☐ Yes: _____drinks/week
Do you exercise regularly? ☐ No ☐ Yes: Type _____ _____times/week

ALLERGIES: ☐ None ☐ Yes, please list: Medication(s):_____ Food: _____
Latex: ☐ Yes ☐ No Seasonal: ☐ Yes ☐ No Other: _____

MEDICAL HISTORY: Please indicate if you have or ever had any of the following:

	Yes	No		Yes	No
High blood pressure			Recent gastrointestinal symptoms/nausea		
Heart or circulation disease/disorders			Illness in the last 3-4 weeks: chills, night sweats, fever, general fatigue, malaise or weakness		
Respiratory disease/disorders			Numbness/tingling		
Cancer			Skin or muscle lumps/thickening		
Diabetes			Unusual weight loss/gain recently		
Arthritis/osteoarthritis			Transplanted organ		
Osteoporosis/osteopenia			Metal implants		
Thyroid disease			Pacemaker		
Seizures			Nutritional/hydration concerns		
Fibromyalgia/myofascial pain syndrome			Unhealed sores/changes in size/shape/color of a mole		
Dizziness or fainting			Recent change in bowel/bladder habits		
History of falls			Other:		

MEDICATIONS: Please list current medications & dosage: _____

_____

_____