DEMOGRAPHIC AND HEALTH HISTORY V24

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICTLY CONFIDENTIAL AND WILL BECOME PART OF YOUR MEDICAL RECORD.

Today's Date:			
Patient Name:	☐ M ☐ F ☐ other	**DOB:**	
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		**Pronouns:**	
Address:	**City:**	**State:**	**Zip:**
Phone:	☐Cell ☐work ☐Home	**Email:**	
SSN #:	**Employer:**	**Responsible Party:**	
Emergency Contact:	**Phone numbers:**		
Referring doctor:	**Phone:**	**Primary Care Doctor:**	

INJURY HISTORY

Is this injury related to a motor vehicle accident?	☐ yes ☐ no					**Is this injury related to work?**	☐ yes ☐ no		
How/when did your problem begin?									
Where do you hurt?						**Describe your pain:**			
Rate your pain (0-10):	Best:		Average:		Worst:		**Is there any numbness?**	☐ yes	☐ no
Check what makes your pain worse:	☐ sitting ☐ standing ☐ walking ☐ bending ☐ cough/sneezing ☐ sleeping ☐ rising from chair ☐ reaching overhead ☐ dressing/grooming								
Check what makes your pain better:	☐ rest ☐ movement ☐ ice ☐ heat ☐ medication ☐ lying down ☐ sitting ☐ standing ☐ moving carefully								
What treatments have you tried?									
What are your goals for PT?									

MEDICAL HISTORY

Your Height:		**Your Weight:**	

Please check if you currently have the following:

☐	Bowel or bladder control problems	☐	Dizziness	☐	GERD
☐	Pain in an extremity	☐	Falling history	☐	Nausea/Vomiting
☐	Numbness/tingling in one or more extremity	☐	Night pain	☐	Ringing in ears
☐	Lack of coordination in walking	☐	Malaise	☐	Hearing problems
☐	Unexplained weight loss or gain	☐	Weakness	☐	Vision problems
☐	Pain with sneezing or coughing	☐	Fever/Chills/Sweat	☐	Pregnancy
☐	Groin/inner thigh numbness	☐	Tendency to bruise/bleed easily	☐	Depression
☐	Pelvic pain or sexual dysfunction	☐	Joint replacements/metal implants	☐	Allergies_____

If you checked any boxes above, please elaborate here:

Please check if you <u>have</u> or <u>have had</u> any of the following:

☐ Heart disease	☐ Stroke/TIA	☐ Asthma
☐ Heart attack	☐ Concussion	☐ Allergies
☐ High cholesterol	☐ Head injury	☐ Chronic Bronchitis
☐ High blood pressure	☐ Parkinson's	☐ Emphysema
☐ Circulatory Disease	☐ Multiple Sclerosis	☐ Lung disease
☐ Pacemaker	☐ Muscular Dystrophy	☐ Tuberculosis
☐ Hyperglycemia	☐ Neurologic condition_____	☐ Cancer
☐ Hypoglycemia	☐ Seizures	☐ Arthritis (Degenerative/Osteo)
☐ Anemia	☐ Migraines/headaches	☐ Arthritis (Rheumatoid)
☐ Hepatitis	☐ Depression	☐ Osteopenia (bone loss)
☐ HIV/AIDS	☐ Chemical dependency	☐ Osteoporosis (bone loss)
☐ Diabetes	☐ Fibromyalgia	☐ Back/neck problems
☐ Kidney problems	☐ Thyroid issues	☐ Herniated disc

If you checked a box, please elaborate here:

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Frequency taken	Purpose

List ALL your past surgeries:

Please check any past injuries in the body parts below.(Everything from a minor sprain to fracture to surgery count)

☐ Ankle:	☐ right	☐ left	**Explain:**			
☐ Knee:	☐ right	☐ left	**Explain:**			
☐ Hip:	☐ right	☐ left	**Explain:**			
☐ Low back:	☐ right	☐ left	**Explain:**			
☐ Middle back:	☐ right	☐ left	**Explain:**			
☐ Neck:	☐ right	☐ left	**Explain:**			
☐ Head:	☐ right	☐ left	**Explain:**			
☐ Shoulder:	☐ right	☐ left	**Explain:**			
☐ Elbow:	☐ right	☐ left	**Explain:**			
☐ Hand/wrist:	☐ right	☐ left	**Explain:**			

I, THE UNDERSIGNED, DO HEREBY CERTIFY THAT I HAVE COMPLETED THE ABOVE INFORMATION AND KNOW IT TO BE TRUTHFUL AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signature:_____ Date:_____