PATIENT HISTORY QUESTIONNAIRE

Date: ___________ Whom may we thank for referring you? ____________

Name: ____ **DOB:** _____________ **Age:** __________

Weight: _______ **Height:** _______ **Blood Pressure:** ___________ **(Circle) R or L Handed**

Home Telephone : _____________ **Cell phone:** _________________ **Home E-mail:** _________________________

S.S.N.: _______________________ **Family Doctor:** ________________________________

Emergency Contact Person:_________________________**Tel#** ___________________

Race: (check one)
White Asian Japanese Samoan Black/African American Asian Indian Korean Filipino
Guamanian Hispanic Chinese Vietnamese American Indian/Alaskan Native
Native Hawaiian or other Pacific Island Multiracial Other ___________ I choose not to specify

Ethnicity: (check one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language: (check one)
English Spanish American Sign Language Chinese French German Tagalog Greek Italian
Vietnamese Korean Russian Polish Arabic Portuguese Japanese French Creole Hindi Urdu
Persian Gujarati Armenian I choose not to specify

Verification Question (choose only one by circling the question, then give the answer to that question):

What is the name of your favorite pet? In what city where you born? What is your favorite movie?
What is your mother's maiden name? On what street did you grow up? When is your anniversary?
What high school did you attend? What was the make of your first car?

Verification Answer to the Chosen question: ______________________________ (Must be 6 characters long)

Do you currently smoke tobacco of any kind? Yes Former Smoker Never been a smoker
If yes, how often do you smoke: Current everyday smoker Current sometimes smoker
If yes, what is your level of interest in quitting smoking? (0=No interest, 10=Very Interested)
0 1 2 3 4 5 6 7 8 9 10

Has any doctor presently diagnosed you with Hypertension? Yes No If yes, describe: ______________________
____ **Onset date:** ________________

Has any doctor presently diagnosed you with Diabetes? Yes No If yes, what kind? Type I Type II
If yes to Diabetes, was your blood work test for hemoglobin A1c >9.0%? Yes No Not sure
If yes, other comments regarding Diabetes____
____ **Onset date:** ________________

Current Medications, including frequency and dosage, if known. If there are no current medications, check here ☐

Medication Name:	Dosage	Frequency	How taken:
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___

List any known allergies you have had to any medications. If no allergies, check here:

____

____

Please list all current medical issues (problem list):

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

Primary Chief Complaint (Check all that apply)

1. What type of pain is it? ☐Sharp/Stabbing ☐Ache ☐Dull ☐Burning ☐Throbbing ☐Numbness ☐Tingling ☐Cramping

2. Rate pain on a scale of 0-10
(Please Circle) (0=no pain, 10=severe pain)

On Average	0 1 2 3 4 5 6 7 8 9 10
At Best	0 1 2 3 4 5 6 7 8 9 10
At Worse	0 1 2 3 4 5 6 7 8 9 10
Over Past week	0 1 2 3 4 5 6 7 8 9 10

3. How long have you had this pain?

____

4. What makes the pain worse? ______________

____

5. What makes the pain better? ______________

____

6. Does the pain travel? _______ If so, where?

____

7. Is pain worse at any particular time of day?

____

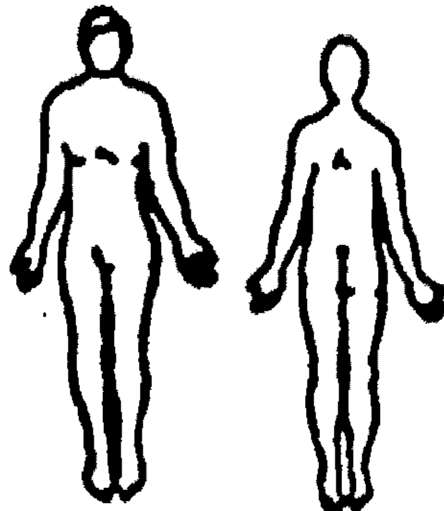
8. Date of onset ____/____/____ Date of same or similar symptoms ____/____/____

9. Is the pain getting better or worse?__________

10. Does the pain wake you up at night? _________

To help us better understand the nature and origin of your complaints, we ask that you carefully complete this drawing. Use the symbols listed below to detail where you hurt and how it hurts on the figures.

///////////////	**Dull Ache/Throb**
XXXXXX	**Sharp/Stabbing**
BBBBBB	**Burning**
OOOOOO	**Numbness**
:::::::::::::::	**Tingling**
CCCCCC	**Cramping**



Have you ever had x-rays? Y N If yes: Date: ________________ For what: ____________________
Have you ever had MRI's? Y N If yes: Date: ________________ For what: ____________________

Have you had an X-ray or CT scan or MRI of your **LOW BACK** spine in the past 28 days ? Yes No

Other Clinical Tests: Have you ever had any of the following tests? Check all that apply

Angiogram Blood tests Doppler Ultrasound Mammogram Urine/Stool tests Bone Scan Biopsy

Echocardiogram Myelogram Stress Tests (Treadmill/Bicycle) Arthroscopy CT Scan NCV/EMG

EEG/EKG/EMG Other: ____________

Is your current condition related to a work injury or an automobile accident? Y N If yes, which one? ________
Have you ever sustained a work injury for which you received treatment? Y N If yes, when? ____________
Have you ever been in an automobile accident? past year past 5 years over 5 years ago never

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Describe your Home/Work/Recreational Activities and any difficulties that you have with these activities:

____

____

With whom do you live: ________________ Do you use an assistive device: Y N Type of device: ____________

Does your home have: Stairs, no railing Stairs, railing Wheelchair Ramps Uneven Terrain Elevator

Obstacles: ____________________ Assistive Devices (e.g. bathroom): ________________________

Do you drink alcohol? Y N If yes, how much/what type do you consume per week

____

Is your history significant for recreational drug use? Y N Describe____________________________

My diet is: balanced not balanced Recent weight change: Gained Lost How much? ____________
My rest is: sufficient insufficient Hours of sleep/night ____________________
I exercise: 0x/week 1-2x/week 3-4x/week 5x/week or more

My recreation is: sufficient insufficent

My family stress is: severe moderate minimal none

Occupation: ____________________________
How do you like your work? above average average below average N/A
My job stress is: severe moderate minimal none N/A

I have experienced: nervousness irritability fatigue depression run down feeling craving for sweets
craving for salts anxiety psychological issues

Does your past history include any hospitalizations or surgeries? Y N If yes, please elaborate on when, where and what.__________

Are you: Single Married Divorced Separated Widowed (circle one)

Do you have any children? Y N If yes, please list their names, sex and ages

____

Do your children have any major medical problems (past or present)? Y N If yes, please describe.

____

Do you have any siblings? Y N If yes, please list any major medical problems that are part of your siblings' history.__________

Are your parents still living? Y N Are there any major medical problems (past or present) that are part of your parents' history? Y N If yes, please describe. __________

Do your maternal or paternal grandparents have any major medical problems (past or present) that are part of their history? Y N If yes, please describe __________

____

Please check the following conditions that you have or have had:

☐AIDS ☐Anemia ☐Arthritis ☐Cancer ☐Diabetes ☐Epilepsy ☐Hardening of the arteries
☐Heart attack ☐High blood pressure ☐Low blood sugar ☐Multiple sclerosis ☐Parkinson's Disease
☐Polio ☐Rheumatic fever ☐Stroke ☐Tuberculosis ☐Venereal Disease

Please check the box if you currently have any of the following symptoms:

Head ☐ N/A

☐ Headaches (R or L) ☐Unusually frequent headaches (R or L) ☐Unusually severe headaches ☐Head feels heavy ☐Vertigo ☐ Dizziness ☐Facial numbness (R or L) ☐Light-headedness ☐Loss of smell ☐Loss of taste ☐Loss of balance ☐Previous head trauma ☐Fainting ☐Sensitivity to light or sound

Neck ☐ N/A

☐Neck pain with movement (R or L) ☐Swelling in neck ☐Stiff neck ☐Pinched nerve in neck (R or L)
☐Dizziness with neck movement ☐Neck feels out of place ☐Muscle spasms in neck
☐Abnormal sounds in neck ☐Previous neck injury

Shoulders ☐ N/A

☐Pain in shoulder (R or L) ☐Pain across shoulders ☐Tension in shoulders
☐Muscle spasms in shoulders ☐Can't raise arm above shoulder level ☐Can't raise arm over head

Arms & Hands ☐ N/A

☐Pain in upper arm (R or L) ☐Pain in forearm (R or L) ☐Pain in hands (R or L) ☐Pain in fingers (R or L)
☐Fingers go to sleep ☐Sensation of pins and needles in arms ☐Sensation of pins and needles in fingers
☐Cold hands ☐Swollen finger joints ☐Sore finger joints ☐Loss of grip strength

Mid back ☐ N/A

☐Pain between shoulder blades (R or L) ☐Mid back pain (R or L) ☐Pain from front to back
☐Pain over kidney area (R or L) ☐Muscle spasms in mid back ☐Pain below shoulder blades with exercise

Low back ☐ N/A

☐Low back pain (R or L) ☐Flank pain (R/L) ☐Muscle spasms in low back ☐ Shooting groin pain

Hips, Legs, & Feet ☐ N/A

☐Pain in buttocks (R or L) ☐Pain down leg (R or L) ☐Knee pain (R or L) ☐Leg cramps ☐Sensation of pins and needles ☐Numbness in legs (R or L) ☐Numbness in toes ☐Cold feet ☐Swollen ankles ☐Swollen feet

Cardiovascular ☐ N/A

☐General swelling ☐Swelling in legs ☐Swelling in face ☐Swelling around eyes ☐Chest pain
☐Heart "jumps" ☐Pounding heartbeat ☐Rapid heartbeat ☐Irregular heartbeat ☐Blue or purple skin
☐Fainting ☐High blood pressure ☐Poor circulation ☐Heart murmurs ☐Difficulty laying flat
☐Chest pain with exercise

Hair, Skin, & Nails ☐ N/A
☐Baldness ☐Dry scalp ☐Oily scalp ☐Eczema ☐Psoriasis ☐Itchy skin ☐Rough, scaly scalp
☐Dry skin ☐Oily skin ☐Yellow skin ☐Bruise easily ☐Pale skin ☐Rashes ☐Skin cancer
☐Sensitive skin ☐Paper thin nails ☐Nail biting ☐Allergies to Chlorine/Bromine

Eyes ☐ N/A
☐Blurred vision ☐Double vision ☐Eyes fatigue easily ☐Excessive tearing ☐Lack of tearing
☐Light bothers eyes ☐Excessive itching ☐Pain in eyeball(s) ☐Periods of blindness in eye(s)
☐Red eyes ☐Night blindness ☐Pain behind eyes

Ears ☐ N/A
☐Loss of hearing (R or L) ☐Pain in ears ☐Discharge from ears ☐Vertigo ☐Ringing in ears

Nose/Nasopharynx/Sinuses ☐N/A
☐Unusual nasal discharge ☐Nose bleeds ☐Pressure over eyes ☐Pressure under eyes ☐Frequent colds
☐Obstruction of nose ☐Sinusitis ☐Nasal allergies ☐Loss of sense of smell ☐Any trauma to nose

Mouth & Throat ☐N/A
☐Pain in mouth ☐Pain in throat ☐Bleeding gums ☐Cavities ☐Abscessed teeth ☐Dentures
☐Difficulty swallowing ☐Changes in voice

Respiratory ☐ N/A
☐Shortness of breath ☐Asthma ☐Chronic cough ☐Difficulty breathing while lying down ☐Dry cough
☐Difficulty sleeping while lying down ☐Productive cough ☐Coughing up blood ☐Wheezing
☐Abnormal chest x-ray

Gastrointestinal ☐ N/A
☐Poor appetite ☐Constant nibbling ☐Indigestion ☐Stomach upsets from food ☐Stomach upsets from liquid ☐Stomach upsets from medicines ☐Abdominal pains ☐Stomach gas before meals
☐Stomach gas with meals ☐Stomach gas after meals ☐Change in bowel habits ☐Diarrhea
☐Constipation ☐Hemorrhoids ☐Ulcers ☐Loss of bowel control ☐Jaundice ☐Liver disease
☐Hepatitis ☐Gall bladder disease ☐ Abdominal bloating # of bowl movements/day__________

Genitourinary ☐ N/A
Urination is: Frequent / Infrequent? Amount is: High / Low? ☐Need to get up at night to urinate
☐Difficult to start/stop urination ☐Painful urination ☐Dribbling ☐Incontinence ☐Blood in urine
☐Cloudy urine ☐Lack of bladder control ☐Back pain with urination ☐Stream flow abnormality

Female Only ☐ N/A
☐Painful periods ☐Missed menstrual periods ☐Irregular cycles ☐Spotting ☐Vaginal discharge
☐Lumps in breasts ☐Wear an IUD ___# of pregnancies ___# of deliveries ___# of vaginal deliver-ies
___# of C-sections ___# of Complicated deliveries ☐LBP w/ menses ☐LBP w/ pregnancy
☐Fibroid tumors ☐Ovarian cysts ☐Nipple discharge ☐ Tubal pregnancy ☐Excessive menstrual flow
☐Premenstrual symptoms Date of last menstrual period_________

Male Only ☐ N/A
☐Impotence ☐Testicular swelling/pain ☐Testicular masses ☐Blood in sperm ☐Prostate disease
☐Premature ejaculation

Cancer
Do you have a history of cancer? Y N If yes, please describe

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Thank you for completing this form.
The information you have provided will assist us in attending to your healthcare needs.

I have read and completed all answers to the above questions to the best of my knowledge. I am aware that answering yes to any of the above questions, may require me to undergo further testing prior to starting any appropriate care. I hereby give my full consent to undergo a rehabilitation exercise program or care designed for me if determined to be clinically medically necessary by my doctor or therapist. I will notify them of any changes in my health status during the duration of the program. It is also my duty to daily inform the doctor, therapist or assistant of any possible complication prior to the initiation of my daily rehabilitation or treatment.

Your signature ______________________________ Date __________

Provider signature ______________________________ Date __________