

Life's Work Physical Therapy

Patient Questionnaire

GENERAL INFORMATION

Today's date: _____ 2008

Tab or mouse through form and fill in blanks

Last Name _____ First _____ Middle _____

Street Address _____ City _____ State _____ Zip _____

Status: Married Single Divorced Other *Check box by clicking, uncheck by clicking again*

Contact methods : *(indicate preference by checking box)*

Home #: _____ Cell #: _____

Work #: _____ Email: _____

Your Employer: _____ Employer Phone _____

Emergency contact _____ Relationship _____ Phone _____

INSURANCE:

Name of insured if different from yours _____ Birth date _____

PROVIDER INFORMATION

How did you hear about our clinic? _____

1. MEDICATIONS

Please list any prescription medications you are taking:

Indicate any over-the-counter medications you are taking:

Advil/Aleve Antihistamines
Antacids Decongestants
Aspirin Tylenol

Supplements/Other _____

2. Right Handed Left Handed

3. FAMILY HISTORY

Indicate (M)Mother (F)Father (B)Brother (S)Sister have had:

_____ Heart disease _____ Hypertension _____ Stroke
_____ Diabetes _____ Cancer _____ Arthritis
_____ Osteoporosis _____ Psychological _____ Other

4. GENERAL HEALTH/LIFESTYLE HABITS

My health is currently: Excellent Good Fair Poor

Life changes in the past year (new baby, job etc)? Y N

I smoke: _____ packs per day _____ cigars/pipes per day

I stopped smoking in _____ (year)

I average _____ (beers, glasses of wine, cocktails) per week.

Beyond normal daily activities, I do the following exercise(s):

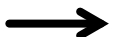
5. HEALTH CHANGES in the past year:

Arm/Leg numbness/tingling	Hoarseness
Bladder problems/changes	Joint pain or swelling
Bowel problems/changes	Loss of appetite
Chest pain	Loss of balance
Coordination problem	Nausea/vomiting
Cough	Other changes (hair loss, perspiration)
Difficulty sleeping	Pain at night
Difficulty swallowing	Pain with squatting/sitting
Difficulty walking	Ringing in ears
Dizziness/blackouts	Oral sensation changes
Drop attacks	Shortness of breath
Fever/chills	Vision problems
Hearing problems	Unexplained weight change
Heart palpitations	Other (explain): _____

6. PAST MEDICAL HISTORY

Allergies	Kidney problems
Anxiety/Depression	Low blood sugar
Arthritis	Lung problems
Balance Disorders	Multiple sclerosis
Broken bones/fractures	Muscular dystrophy
Bronchitis	Neurological
COPD	Osteoporosis
Cancer	Parkinson's Disease
Development/growth problems	Pneumonia
Diabetes	Motor Vehicle Accident(s)
Epilepsy/seizures	Repeated infections

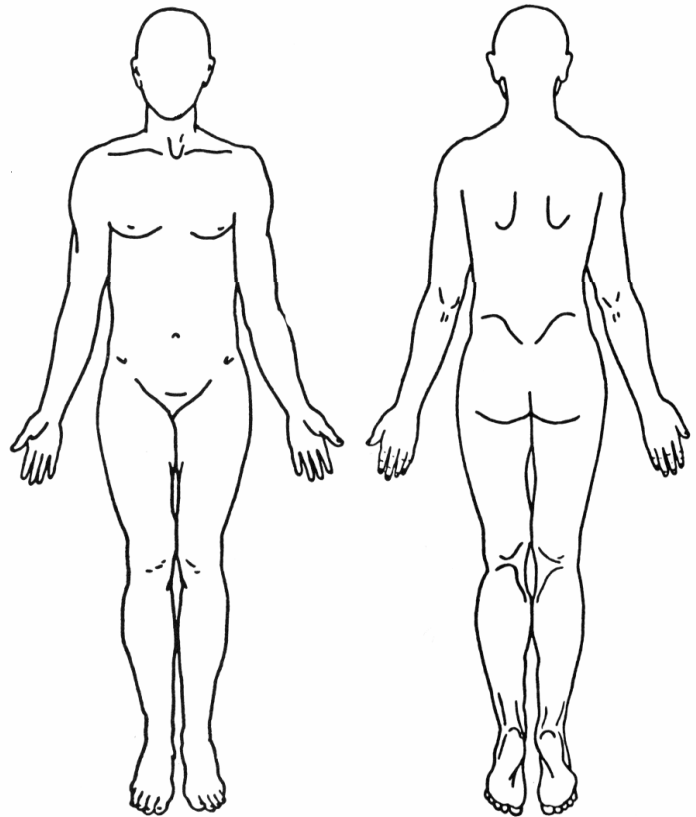
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6. PAST MEDICAL HISTORY (continued)

- | | |
|----------------------------|------------------------|
| Fibromyalgia | Skin diseases |
| Head injury | Sleep apnea |
| Headaches/migraines | Sprain or strain |
| Heart problems | Stroke |
| Hepatitis | Thyroid problems |
| High Cholesterol | Trauma |
| Hypertension | Ulcer/stomach problems |
| Infectious disease (eg TB) | Whiplash |

Click or place an X to indicate where you feel pain:



7. SURGERY

Please list where/when you've been hospitalized or had surgery.

8. REPRODUCTIVE HEALTH

Have you ever experienced:

- Prostate disease (*men only*)
- Pregnancy/delivery complications (*women only*)
- Current pregnancy (*women only*)
- Endometriosis (*women only*)
- Menstrual trouble (*women only*)
- Other OB/GYN difficulties (*women only*)
- Pelvic inflammatory disease (*women only*)

If so, please describe:

9. CURRENT CONDITIONS / CHIEF COMPLAINT(S)

Please describe your problem

Date when current problem began: _____

Does anything make the problem(s) better?

Does anything make the problem(s) worse?

OTHER CLINICAL TESTS in the past year:

- | | |
|--------------------|-------------------------|
| Angiogram | Mammogram |
| Arthroscopy | MRI |
| Biopsy | Myelogram |
| Blood tests | Nerve conduction test |
| Bone scan | Pap smear |
| Bronchoscopy | Pulmonary function test |
| CT scan | Spinal tap |
| Doppler ultrasound | Stool test |
| Echocardiogram | Ultrasound |
| EEG | Urine test |
| EKG | X-rays |
| EMG | Other: |

Place an X on scale below to indicate your worst pain in the last 24 hrs.

0 10
No Pain Worst Pain Imaginable

10. SOCIAL HISTORY

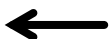
Are there any customs/religious beliefs that may impact your care? Y N

Have you completed an advanced directive (e.g. CPR)? Y N

I am (check all that apply) a full time or part-time student

Job title/duties:

Is this a full duty or light duty position?



BACK