

HEALTH QUESTIONNAIRE FORM



Please check which clinic you will be attending therapy at.
Please remember to bring your insurance card.

- { } Belvidere Physical Therapy, Belvidere, IL
- { } Marengo Physical Therapy, Marengo, IL
- { } McHenry County Physical Therapy, McHenry, IL
- { } Ogle County Physical Therapy, Byron, IL
- { } Roscoe Physical Therapy, Roscoe, IL

Patient Name: _____ Age: _____
(Last and suffix, i.e. Sr., Jr.) (First) (MI)

DOB: ___/___/___

Who referred you for physical therapy? _____

Please rate your general health status: (circle one) **Excellent** **Good** **Fair** **Poor**

Please describe the problem for which you seek physical therapy: _____

When did the problem(s) begin (date)? _____

Is the problem related to a specific injury? _____

Please describe your pain: (circle one) **Sharp** **Dull** **Constant** **Periodic**

Is there anything that you do that relieves the pain? If so, what? _____

What movement or activities increase your pain? _____

Have you had this problem(s) before this episode? _____
 If so, did the problem(s) get better? _____
 How long did the problem(s) last? _____

Please list any special test(s) performed that relate to this problem(s) and the dates of the test(s):

Please list any medications you are currently taking: _____

Using the following scale, please mark your pain level at this time: **0= No pain** **10= Emergency room pain**

0-----10

What type of exercise activities do you currently do and how often? _____

Is there any chance that you are pregnant? (circle one) **Yes** **No**

Do you have a history of:

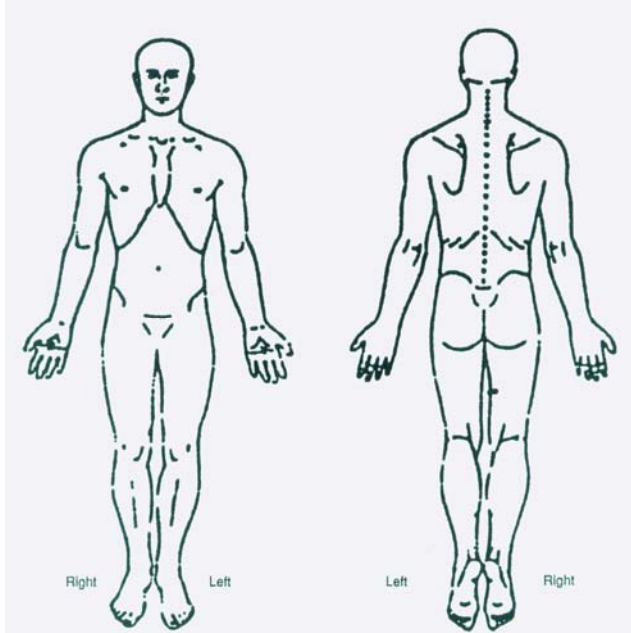
	Yes	No		Yes	No		Yes	No
High Blood Pressure			Pacemaker			Respiratory Disorder		
Heart Condition			Seizures			Metal Implants		
Stroke			Cancer			Other Implants		
Diabetes			Falls			Other _____		
Dizziness			Other _____					

Patient/ Guardian Signature: _____ Date: _____

Reviewed by therapist: _____ Date: _____

Using the following pictures, indicate where your pain is located. Using these symbols describe your type of pain:

Numbness === Aches ^^ ^ Pins/needles 000 Stabbing /// Burning XXX Cramping +++ Sharp ***



Are your symptoms affecting your ability to work or otherwise be active? _____ If so, how? _____

Current limitations: (check all that apply)

- Difficulty with movement
- Getting in and out of bed or up and down from a chair
- Changing positions in bed
- Difficulty with grooming and bathing
- Walking: level stairs ramps uneven terrain

Difficulty with home management (household chores, yard work, driving, shopping): _____

Difficulty with community and work activities (work, school, play, recreation): _____