THERAPY HEALTH HISTORY QUESTIONAIRE

Please fill in form as completely as possible. Include any additional information as necessary.

Name: ____ Age:_______ Today's Date:___________________

What is the primary problem or chief complaint that you would like addressed in therapy: _________________
____

Date of onset: ________ Recent tests (circle): x-rays, CT, MRI and results if known:_____________________

Please circle **current** pain 0 1 2 3 4 5 6 7 8 9 10

No Pain Severe pain

What is your highest pain rating over the last 3 days: _____ Lowest pain rating: ______

Does pain wake you at night? ○Yes ○No

For the following questions, please check all that apply or fill in words that describe your condition

What makes your pain worse? ○sitting ○standing ○walking ○exercise_____________________________

What makes your pain better? ○sitting ○lying down ○heat ○ice ○medications_______________________

Are your symptoms getting ○better ○worse ○staying about the same________________________________

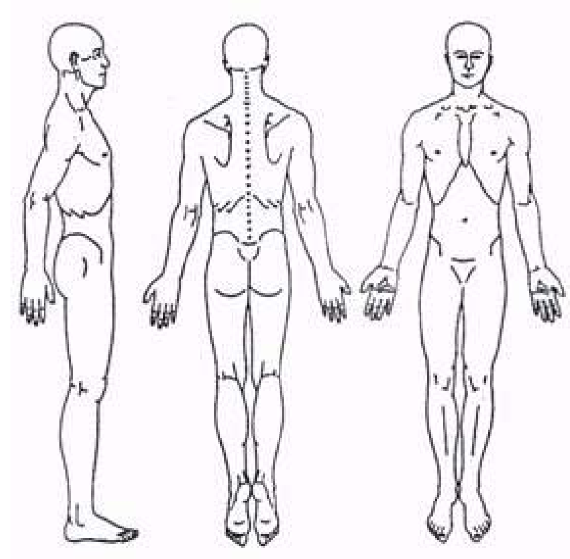
Are you pregnant? ○ **YES** ○ **NO** ○ **NA**

Cont'd…/2

Please indicate on the diagram the location of your current pain. Describe your pain (example: sharp, dull, ache, stabbing, numbness, shooting, throbbing, tingling, pulling, or tight)

____

____



Which best describes symptoms (check one)

○ Constant

○Intermittent (relieved with some positions or rest)

○Occasional (daily or less frequent)

○Infrequent (once a week or month)

○Variable (sometimes worse than other times)

What are your current goals for therapy (check all that apply) ○return to work ○increase motion ○increase strength ○increase function ○improve balance ○improve walking ability ○other______________________

MEDICAL HISTORY

Please check problems for which you have seen a physician or have been treated for:

Diabetes	○Yes ○No	Thyroid Condition	○Yes ○No
Tumor	○Yes ○No	Blood Clots	○Yes ○No
Stroke	○Yes ○No	Anxiety	○Yes ○No
COPD	○Yes ○No	Bleeding Disorder	○Yes ○No
Blood Pressure	○Yes ○No	Arthritis	○Yes ○No
Heart Problem	○Yes ○No	Seizure	○Yes ○No
Asthma	○Yes ○No		

Cancer ○Yes ○No If yes what kind?____

Cont'd…/3

Have you had any surgeries? ○Yes ○No

Please list____

____

Do you have any allergies? ○Yes ○No List____

Have you ever had a skin reaction to adhesive tape? ○Yes ○No

Do you have any metal implants? ○Yes ○No List____

Do you have a pacemaker? ○Yes ○No

Are you taking any medications? ○Yes ○No

Please list: ___________________________ ________________________________

___________________________ ________________________________

___________________________ ________________________________

Do you have a follow up with your **referring** physician? ○Yes ○No If yes, when______________________

ARE YOU CURRENTLY RECEIVING HOME HEALTH SERVICES? O YES O NO