PATIENT HISTORY QUESTIONNAIRE

South Lane Physical Therapy LLC

PLEASE FILL OUT THIS FORM AS COMPLETE AS POSSIBLE. IT WILL ASSIST YOUR THERAPIST IN DEVELOPING A PLAN OF CARE FOR YOU. IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO ASK FOR ASSISTANCE. THIS INFORMATION WILL REMAIN CONFIDENTIAL UNLESS AUTHORIZED FOR RELEASE BY THE PATIENT.

NAME ____ DATE OF BIRTH: ____________________________

OCCUPATION ______________________________________ HOBBIES: _________________________________

DATE OF INJURY ________________ PLEASE CIRCLE: SUDDEN ONSET GRADUAL ONSET

HAS THIS INJURY PREVENTED YOU FROM WORKING? YES NO IF YES, HOW LONG OFF WORK______

WORK STATUS: AT THE **PRESENT TIME** I AM ABLE TO:

_______ Work without restrictions
_______ Work the same job with restrictions
_______ Work a different job with restrictions
_______ Unable to work due to dysfunction
_______ Don't normally work outside the home
_______ Homemaker
_______ Retired
_______ Other

IS AN ATTORNEY INVOLVED WITH THE CASE? YES NO

IF YES, ATTORNEY NAME: _________________________________ PHONE: ________________________

HAVE YOU SOUGHT PREVIOUS TREATMENT FOR THIS CONDITION?

_______ No other treatment
_______ Massage Therapy
_______ Chiropractor
_______ Physical/Occupational Therapy
_______ Psychiatrist/Psychologist
_______ Other: ______________

LIST ALL PRESCRIPTION MEDICATION YOU ARE TAKING (Including injection and skin patches: __________________

____

____

LIST ALL OVER-THE-COUNTER MEDICATIONS YOU ARE TAKING (Including vitamins and supplements):

____

____

PLEASE LIST ANY SURGERIES OR OTHER CONDITIONS FOR WHICH YOU HAVE BEEN HOSPITALIZED:

DATE	SURGERY/HOSPITALIZATION	REASON
_______	______________________________	______________________________
_______	______________________________	______________________________
_______	______________________________	______________________________

ARE YOU CURRENTLY HAVING OR HAVE EXPERIENCED ANY OF THESE SYMPTOMS IN THE PAST 3 MONTHS?

_______ Fever
_______ Chills
_______ Night Sweats
_______ Shortness of Breath
_______ Pins/Needles
_______ Numbness
_______ Skin Rash
_______ Headaches
_______ Vision Problems
_______ Hearing Loss
_______ Bowel/Bladder Problem

PLEASE CHECK ALL THE FOLLOWING CONDITIONS THAT APPLY TO YOU EITHER PRESENTLY OR IN THE PAST

_______ High Blood Pressure _______ Epilepsy/Seizures _______ Gout _______ Varicose Veins

_______ Chest Pain/Heart Attack ______ Kidney Disease _______ Hepatitis _______ Dizziness/Fainting

_______ Stroke _______ Asthma _______ Arthritis _______ Depression

_______ Heart Disease _______ Emphysema/Bronchitis _______ Tuberculosis _______ Lung Disease

_______ Cardiovascular Disease _______ Hearing Loss _______ Thyroid Problems

_______ Emotional/Psychological Problems _______ Chemical Dependency (alcohol/drugs)

_______ Allergies: ____

_______ Other: ____

HAS ANYONE IN YOUR IMMEDIATE FAMILY (Parents, Brothers, Sisters) EVER BEEN TREATED FOR ANY OF THE FOLLOWING?

_______ Cancer _______Heart Disease _______Diabetes ______ Tuberculosis ________ Mental Disorder

_______ Arthritis ______ High Blood Pressure _______ Kidney Disease _______ Stroke

HAVE YOU RECENTLY EXPERIENCED ANY SIGNIFICANT CHANGES IN:

_______ Mood _______ Energy level (restlessness, lethargy, or fatigue)

_______ Interest or pleasure in daily activities _______ Recurrent thoughts of death or harming yourself

_______ Loss/Gain of appetite or weight loss/gain _______Sleeping habits

How many packs of cigarettes do you smoke per day? ______________________________________

How many days per week do you drink alcohol?______________ How much do you drink at an average sitting?_________

Are there any other substances that you regularly use?______________________________________

ARE YOU AWARE OF YOUR CURRENT DIAGNOSIS? YES NO

DO YOU HAVE QUESTIONS REGARDING YOUR DIAGNOSIS OR PROGNOSIS YES NO

RATE YOUR AVERAGE DISCOMFORT ON THE SCALE BELOW

0 ____ 10

(no pain) (severe pain)

PLEASE MAP YOUR AREAS OF DISCOMFORT OR ALTERED SENSATION ON THE BODY MAP:

XXX = Pain 000 = Numb/Tingle *** = Weakness

OTHER COMMENTS OR CONCERNS YOU MAY HAVE:

____

____

____

Form reviewed by therapist:

_____________ (PT initials) _____________ Date