Loudoun Physical Therapy - Patient Health History Intake Questionnaire

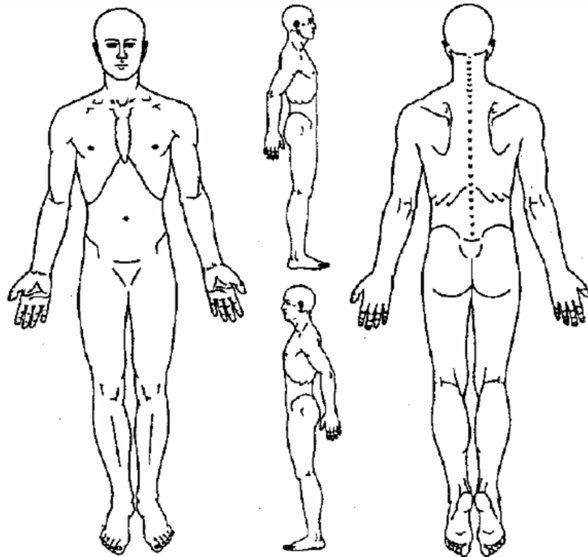
Patient Name: ____ Date: ___________
Injury onset date: _________________ (If symptoms > than 1 year, date at which symptoms began worsening)

Primary Complaint: ____
How did this condition/injury begin? ____
Was surgery performed? YES NO Date: _______ Type: ______________________
Prior hospitalization? YES NO Dates: _______
Dates of: Last physician appointment: _______ Next physician appointment: _______

Pain: In the last 24 hours, please rate your pain range at its highest, lowest, and current levels

	None		Low		Moderate			High		Worst Imaginable	
Worst	0	1	2	3	4	5	6	7	8	9	10
Current	0	1	2	3	4	5	6	7	8	9	10
Best	0	1	2	3	4	5	6	7	8	9	10

Please Mark Location of Pain or Discomfort on Diagram Below: If multiple sites of pain, identify numerically (i.e. P1, P2, P3…)



Describe your pain:
Burning, Dull/Achy, Throbbing, Sharp, Shooting, Numbness/Tingling, Other:____________________

Are your symptoms:
CONSTANT INTERMITTENT

Since onset are your symptoms:
WORSENING IMPROVING STAYING THE SAME

What worsens your symptoms?
____

What improves your symptoms?
____

Previous history of similar symptoms? YES NO How many episodes? ____ Year of first episode: ____

Have you been treated for this condition in the past 6 months? YES NO Type of Treatment: ___________

Prior to this injury, did you have any limitations with functional and daily activities? YES NO
Describe: ____

Do you work full time? YES NO Has this Injury changed your ability to work? YES NO
Occupation: ____
Summarize the physical requirements required for your job: _________________________________
____

Medical History: Circle all that apply ❑ No known significant past medical history

Cancer	Stroke	Heart Problems	High Blood Pressure	Fractures
Depression/Anxiety	Diabetes	Thyroid Disease	Respiratory Problems	Brain Injury
Osteoarthritis	Rheumatoid Arthritis	Osteoporosis	Blood Clots	Immunosuppression
Lyme's Disease	Fibromyalgia	Lupus	Current Infection	Currently Pregnant
Vision/Hearing Loss	Chemical Dependency	Metal Implants	Other: ______________________________	

Please explain any of the above if needed: ____

____

Do you have a family history of any of the above? YES NO Explain:________________________________
Surgical History: ____
Do you have a pacemaker? YES NO
Do you smoke? YES NO Packs/Day: _______ Do you drink alcohol? YES NO Glasses/Day: ________

Are you allergic to Latex? _________ Identify any additional allergies: ______________________________

*Body Mass Index Weight: ____ lbs Height: ____inches *Required for Medicare

Have you recently had any of the following? Circle all that apply

Fever, Chills, Sweats	Bowel/Bladder Changes	Night Pain	Unexplained Weight Change
Appetite Change	Nausea/Vomiting	Headaches	Dizziness/Lightheadedness
Chest Pain	Numbness/Tingling	Fatigue	Shortness of Breath
Confusion	Difficulty Talking	Sleep Disturbance	Seizures
Decreased Balance	Difficulty Walking	Fear of Falling	Weakness

History of Fall in the past 12 months? YES NO How many times? ____ Any injuries? ______________

Have you received Home Health Physical Therapy? YES NO Dates: _________________
Company providing Home Health Care: ____

Because of your condition do you feel down, depressed, or hopeless? YES NO
Because of your condition do you feel you have little interest or pleasure in doing things? YES NO
Is this something you would like help with? YES YES, but not today NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Diagnostic Testing: X-rays, MRI, CAT scan, EMG/NCS, Other: ____________________ Date:________

Current Medications: (Include prescription and over the counter) ❑ Not currently taking medications

____
Are you currently taking blood thinners? YES NO Explain: ______________________________________

Identify at least 3 activities that are important to you that you are currently unable to perform or have increased difficulty with since the onset of your symptoms:

1. ________________________ 2. ________________________ 3. ________________________

PATIENT GOALS: Please summarize your goals and expectations for physical therapy

____
____

Patient Signature: ___________________________ Therapist Signature: ___________________________ Date: ________