kitsap physical therapy
AND SPORTS CLINICS

Health Information

Self-rate general health:
❑ excellent ❑ fair ❑ poor

Do you get moderate exercise in your daily routine?
❑ never ❑ 1-2 days/wk ❑ 3+ days/wk

Do you smoke? ❑ no ❑ yes Packs/day _____

Weight: _____ **Height**: _____ **BMI**: _____

What is your stress level?
❑ low ❑ medium ❑ high

Are you seeing any other health professionals for this condition? _____

Are you seeing any other rehab professionals at this time? _____

Functional Level prior to onset of this condition

❑ **Independent** with all activities (work/home/recreation/shopping)
Have you fallen in the past year/how many times? _____
Were you injured in any falls? ❑ yes ❑ no

Self Care
❑ Independent in all self-care (dressing/bathing/toileting)
❑ Difficulty performing self-care
❑ Need assistance with self-care

Social
❑ Need assistance with activities outside home

Hobbies: _____

Living Circumstances

❑ live alone ❑ live with family/spouse
❑ retirement home ❑ assisted living ❑ live w/caregiver

Setting
❑ stairs (w/railing) ❑ no stairs ❑ stairs (no railing)
❑ ramp ❑ elevator ❑ other

Occupational Information

Occupation: _____
❑ full time ❑ part time ❑ unemployed
❑ homemaker ❑ retired ❑ student

Work activities (check all that apply):
❑ sitting ❑ phones ❑ heavy equip op
❑ standing ❑ mod/heavy lifts ❑ driving
❑ computer use ❑ repetitive lifting ❑ repetitive motions

Currently receiving/seeking disability for this condition? Y/N
If not performing your normal activities at work, do you plan to return to your previous activity level? Y/N

Family History

Has anyone in your immediate family (parents/siblings) ever been treated for any of the following?
Explain: _____
❑ diabetes ❑ liver disease ❑ heart problems
❑ cancer ❑ stroke ❑ high blood pressure
❑ kidney disease ❑ osteoporosis ❑ tuberculosis
❑ arthritis ❑ depression ❑ other

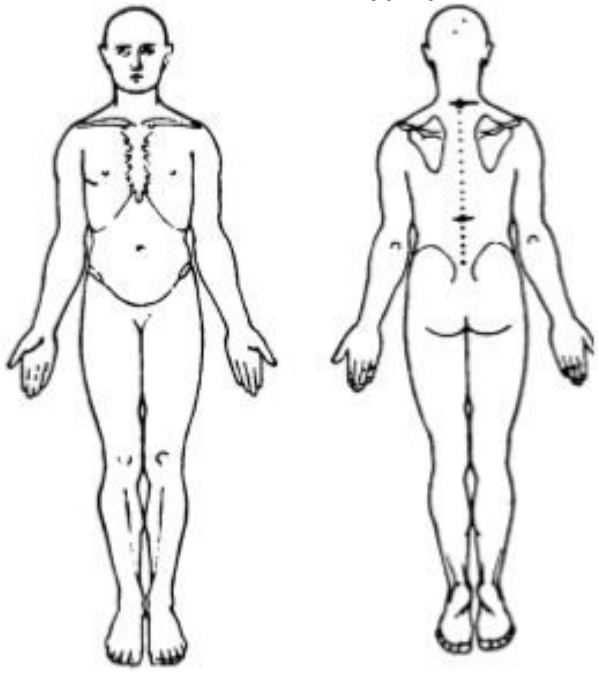
PATIENT QUESTIONNAIRE/HEALTH HISTORY

NAME: _____
DATE: _____

Present Condition History

1.What are your symptoms?

Mark areas of pain or abnormal sensation on the body chart below ⬇ (shade in where appropriate)



2. When did your symptoms related to this problem begin?
(please indicate a specific date if possible) _____

3. Was the onset of this episode gradual or sudden?
❑ gradual ❑ sudden

4. Which of the following best describes how your injury occurred? (check one):
❑ unknown ❑ trauma ❑ throwing
❑ lifting ❑ degenerative process
❑ a fall ❑ MVA (car accident)
❑ cumulative trauma ❑ a blow to body
❑ dental procedure ❑ running/sports
❑ other: _____

5. Since onset, are your symptoms getting (check one):
❑ better ❑ worse ❑ unchanged

6. Have you had similar symptoms in the past?
❑ yes ❑ no How many times? _____

7. Nature of pain/symptoms (check all that apply):
❑ constant ❑ sharp/stabbing ❑ tingling/numb
❑ intermittent ❑ burning ❑ fluctuating intensity
❑ aching ❑ throbbing ❑ other _____

8. As the day progresses, do your symptoms (check one):
❑ increase ❑ decrease ❑ stay the same

9. Does the pain wake you at night?

❑ yes ❑ no If yes, is it present:

❑ while lying still ❑ only when changing positions ❑ both

10. Do you have pain/stiffness upon getting out of bed?

❑ yes ❑ no

11. In what position do you sleep?

❑ right side ❑ chair/recliner ❑ back

❑ left side ❑ back/side/stomach ❑ stomach

12.Since the onset of your current symptoms, have you had:

❑ fever/chills ❑ numbness ❑ weakness

❑ night pain/sweats ❑ difficulty w/control of bowel/bladder

❑ unusual fatigue ❑ numbness in genital/anal areas

❑ nausea ❑ any dizziness or fainting attacks

❑ vomiting ❑ unexplained weight change

❑ headaches ❑ malaise-vague feeling of bodily discomfort

❑ swallowing trouble ❑ problems with vision/hearing

13. What aggravates your symptoms (check all that apply)

❑ sitting ❑ eating any or certain foods

❑ standing ❑ talking/chewing/yawning

❑ stairs ❑ going to/rising from sitting

❑ squatting ❑ coughing/sneezing

❑ walking ❑ taking a deep breath

❑ bending forward ❑ looking up overhead

❑ sustained bending ❑ reaching overhead

❑ stress ❑ reaching behind back

❑ swallowing ❑ sleeping

❑ lying down ❑ household activities incl _____

❑ recreation/sports/hobbies incl _____

❑ repetitive activities incl _____

❑ other _____

14. What relieves your symptoms? (check all that apply)

❑ sitting ❑ rest ❑ massage

❑ heat ❑ standing ❑ medication

❑ cold ❑ walking ❑ nothing

❑ stretching ❑ exercise ❑ splints/brace

❑ lying down ❑ other _____

15. Previous treatments you have had? (check all that apply)

❑ none ❑ injection into the spine

❑ medication (oral) ❑ injection into skin/muscles

❑ physical therapy ❑ TENS unit

❑ chiropractic ❑ acupuncture

❑ massage ❑ bed rest

❑ exercise ❑ overnight hospitalization

❑ bracing/splinting ❑ casting

❑ taping ❑ surgery

❑ traction ❑ biofeedback

❑ radiation ❑ other _____

❑ chemotherapy ❑ _____

16. Have you had any of the following tests related to THIS current issue?

❑ none ❑ stress x-ray test ❑ arthrogram

❑ x-rays ❑ bone scan ❑ NCS

❑ CT scan ❑ MRI

Results: _____

Medications

List **all** medications**. Medicare patients** must provide a detailed list of medications and supplements including dosage, frequency and route (i.e. oral, topical, inhaled…) either separately or below – and must be signed:

Med Name	**Dosage**	**Frequency**	**Route**

Currently taking any of the following over-the-counter medications, or others? _____

❑ aspirin ❑ antihistamines ❑ Tums/antacids

❑ Tylenol ❑ vitamins ❑ mineral supplemt

❑ corticosteroids ❑ Advil/Motrin/Ibuprofen

Your Prior/Current Medical Status

Have you ever had/been diagnosed with any of the following conditions (check all that apply):

❑ allergies ❑ cancer (type) _____

❑ arthritis ❑ circulation/vascular problems

❑ blood disorder ❑ infectious diseases

❑ depression ❑ neurological disorder

❑ kidney problems ❑ epilepsy/seizures

❑ lung problems ❑ head injury

❑ osteoporosis ❑ Multiple Sclerosis

❑ rheumatoid arthritis ❑ Parkinson's Disease

❑ stomach problems ❑ stroke

❑ ulcers ❑ heart problems

❑ thyroid issues ❑ high blood pressure

❑ dementia ❑ do you have a pacemaker? **Y/N**

❑ diabetes-**date of diagnosis (or estimate)**_____

Surgery

Please list any recent/relevant past surgeries related to your current problem:

Surgery	**Date**

During the past months have you been feeling down, depressed or hopeless? **Yes/No**

During the past month have you been bothered by having little interest or pleasure in doing things? **Yes/No**

Is this something with which you would like help? **Yes/No**

Your goal for physical therapy: _____

To the best of my knowledge the above information is true, complete & accurate:

Patient/Guardian signature: _____

Date: _____