Central Mountain PT- Patient History Questionaire

Patient Name: _____ Date: _____

1. Describe your symptoms _____

   When did your symptoms start?_____

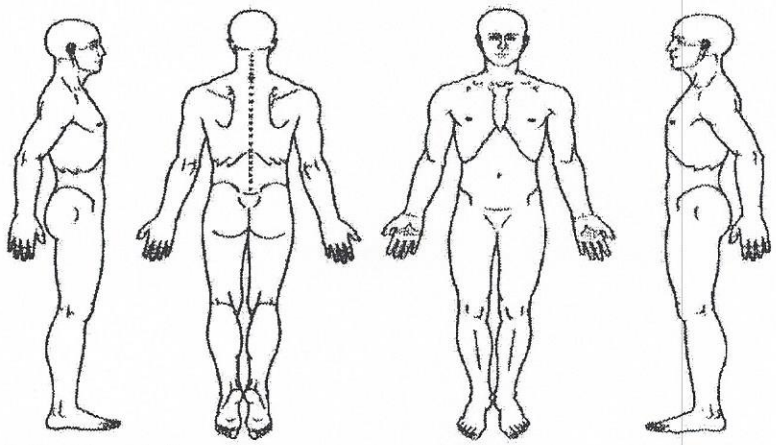
   How did your symptoms begin? _____

2. How often do you experience your symptoms?
   ① Constantly (76-100% of the day)
   ② Frequently (51-75% of the day)
   ③ Occasionally (26-50% of the day)
   ④ Intermittently (0-25% of the day)

3. What describes the nature of your symptom
   ① Sharp ④ Shooting
   ② Dull ache ⑤ Burning
   ③ Numb ⑥ Tingling

4. How are your symptoms changing?
   ① Getting better
   ② Not changing
   ③ Getting worse

Indicate where you have pain or other symptoms



5. **Please place a check next to the word(s) that best describe your symptoms:**
   Muscle Soreness Stiffness Other: _____ Doesn't Apply

   What makes your symptoms better? _____

   What makes your symptoms worse? _____

   At the present time would you say your health is? Excellent Very Good Fair Poor (If the beneficiary is unable to respond, indicate why?) _____

6. **Where do you currently reside and do you need additional assistance in your home environment to manage your current diagnosis/limitations?**

   _____

7. **Do you expect any changes to your current living environment (and/or help needed) once you have been discharged from out-patient Physical Therapy**:_____

8. **On the scale below, please circle the number which best represents your pain level at rest:**
   (None=0) (Unbearable=10)
   0 1 2 3 4 5 6 7 8 9 10

9. **Please circle the number below which best represents your pain level with activity:**
   (None =0) (Unbearable= 10)
   0 1 2 3 4 5 6 7 8 9 10

10. **Who have you seen for your current symptoms in the past year?**

    No one Family MD Orthopedic Surgeon Physical Therapist Chiropractor
    Other_____

11. What tests have you had for your symptoms (check all that apply)?

None X-rays MRI CT scan Other: _____

12. What is your occupation? _____ **Are you:** Full time Part Time Off Work

13. Self Employed? Yes No

Any Current Work Limitations? (Light duty and/or physician ordered limitations): No Yes **(Please List)**

_____

14. Past Medical History: Please check each condition that you have been told you have:

Diabetes	Asthma	Lung Disease	Kidney Disease	Angina/Chest Pain
Stroke	Fibromyalgia	Heart Disease	Pacemaker	High Blood Pressure
Cancer	Osteoporosis	Arthritis	Other:_____	
Depression	Anxiety			

HEIGHT: _____ **WEIGHT**: _____

15. Please List significant injuries and/or surgeries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury & surgery:

_____

_____

16. Please list (or provide a copy**) of prescription medications and/or over the counter meds you are taking:**

_____

_____

17. What are your goals in coming for treatment?

_____

18. List any Allergies: _____

19. Are you allergic to Latex? No Yes

20. Have you fallen in the Past Year? No Yes **How many times:** _____

21. Do you use an assistive device? No Yes **What type:** _____

22. Who is your referring Doctor? _____ **Family Doctor?** _____

23. When is your next Doctor appointment (with referring doctor)? _____

Patient Signature: _____ **Today's Date:** _____