Advanced Therapy Specialists
Physical Therapy | Occupational Therapy

# HEALTH QUESTIONNAIRE

**PATIENT NAME:** ______________________________________________________________

**PATIENT DATE OF BIRTH:**_________ **TODAY'S DATE:** ____________________

Your answers to the following questions will help us to understand your medical history and concerns. Please fill out as much of this questionnaire as possible. If you cannot answer some of the questions or feel uncomfortable answering them, leave them blank. Thank you for your help.

**Reason for your visit today?** ________________________________________________________

**How long have you had this condition?** ____________________________________________

**Have you received Physical Therapy or Occupational Therapy during this calendar year?**

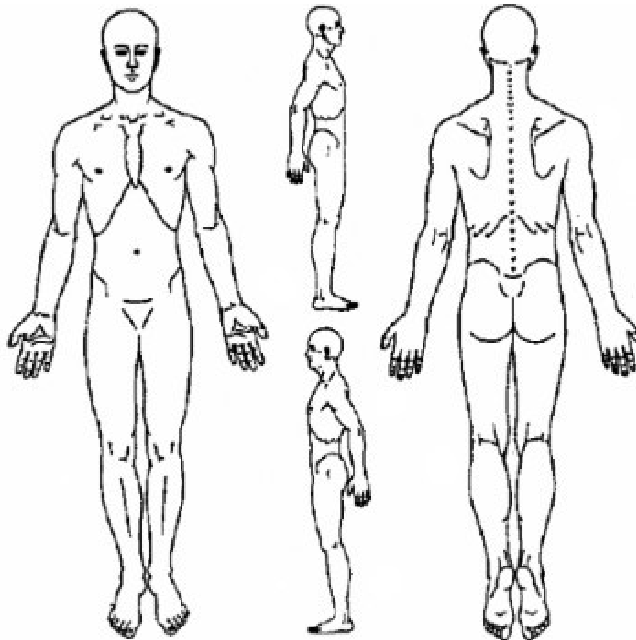
**Yes** _____ **No**_____ **If Yes, please list:** _____________________________________________

**Are you CURRENTLY receiving HOME CARE or other rehab services? YES**________ **NO**___________

**Height**____________ **Weight**____________ **Shoe Size**____________ **Dominant Hand: Right or Left (circle one)**

**<u>INSTRUCTIONS:</u>** Please use the diagram below to indicate your current symptoms. Use the key to indicate the type of symptoms.

Pins and Needles = 000000 Stabbing = / / / / / /
Burning = xxxxxxx Deep Ache = zzzzzz



Please rate your current level of pain on the following scale (circle one):

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| (no pain) | | | | | | | | | | (worst imaginable pain) |

**More questions on reverse side**

# MEDICAL HISTORY

**Please list any surgeries or hospital stays you have had and their approximate date/year**:
*Type of surgery / reason for hospitalization/Year*

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

**Please list <u>all</u> medications, including vitamins, herbal or natural supplements and prescription medications, which you are currently taking. Please note the dosage if possible.**
***If you have a current list, we can make a copy for our records.***

*Medication Name*

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Please list any **allergies or medication reactions**:

____________________________________________________________
____________________________________________________________

**Please check to indicate if you have ever had the following conditions:**

| | | | |
|---|---|---|---|
| ☐ Anemia | ☐ Fatigue / Weakness | ☐ Latex Allergy | ☐ Surgical Implants |
| ☐ Anxiety | ☐ Headaches | ☐ Metal Implants | ☐ Swelling in Ankles |
| ☐ Arthritis | ☐ Head Injury / Concussion | ☐ Numbness / Tingling | ☐ Thyroid |
| ☐ Asthma | ☐ Heart Disease / Attack | ☐ Osteoporosis | ☐ Vascular Disease |
| ☐ Cancer | ☐ Hepatitis | ☐ Pacemaker | ☐ Chemotherapy |
| ☐ Depression | ☐ High Blood Pressure | ☐ Seizures / Epilepsy | ☐ Radiation |
| ☐ Diabetes | ☐ HIV / AIDS | ☐ Shortness of Breath | ☐ Other (please list) |
| ☐ Dizziness/Light-headedness | ☐ Hypersensitivity to Heat /Cold | ☐ Stroke | |

**If you have marked any conditions above, please explain:**

____________________________________________________________
____________________________________________________________
____________________________________________________________