

GOTHAM PHYSICAL THERAPY

Patient Questionnaire/History

Name: _____ Date of Birth: _____ Right handed Left handed

What is your Chief Complaint? _____

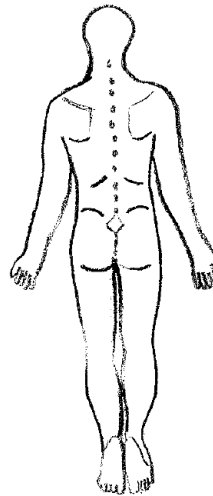
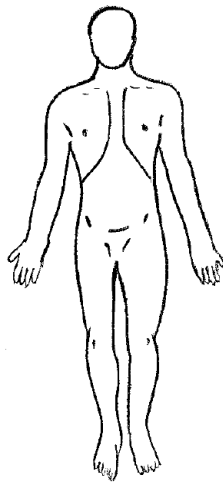
Rate your chief complaint in order of severity from worst (5) to least (1)

____ Pain ____ Decreased Motion ____ Swelling/edema ____ Stiffness ____ Loss of function

Indicate the nature of your pain and symptoms:

- Sharp Dull Piercing Shooting Aching Deep
 Superficial Tingling Numbness Intermittent Burning Stabbing

Where is the problem? (Use the diagram below) Pain **xxx** Numbness **///** Tingling **ooo** Shooting Pain **>>>**



When and how did this problem begin? _____

What makes your symptoms/pain worse? _____

What makes your symptoms/pain lessen? _____

Are your symptoms worse in the: Morning Afternoon Evening Inconsistent

Are your symptoms: Improving Worse Stable

Rate your pain (0-10) **0** – no pain **10** – excruciating pain:

____ Worst it has been ____ Past 2 to 4 weeks ____ Past 24 hours ____ At this moment

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Medical History

Has this problem affected your daily life or routine? Briefly describe in what ways. _____

Have you had previous similar occurrences of your symptoms? Yes No

Describe: _____

What if any treatments have you had for this current problem — please check the disciplines which apply:

- | | | | |
|--|---|-------------------------------------|---|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Acupuncture | <input type="checkbox"/> M.D. | <input type="checkbox"/> Prescribed Medications |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Pilates | <input type="checkbox"/> General Exercise |
| <input type="checkbox"/> Exercise with trainer | <input type="checkbox"/> Self medicated (Advil) | <input type="checkbox"/> Ignored it | <input type="checkbox"/> Other |

Did they help to alleviate your symptoms? _____

Have you had any special tests for this condition? (X-rays, MRI's, ETC) If yes, do you know the results?

Please answer the following questions:

	Yes	No
1) Do the current problems interrupt your sleep?	<input type="checkbox"/>	<input type="checkbox"/>
2) Do your symptoms change with coughing or sneezing?	<input type="checkbox"/>	<input type="checkbox"/>
3) Have you had any recent changes in bowel or bladder function?	<input type="checkbox"/>	<input type="checkbox"/>
4) Do you experience any dizziness or vertigo?	<input type="checkbox"/>	<input type="checkbox"/>
5) Have you had any recent change in your weight or appetite?	<input type="checkbox"/>	<input type="checkbox"/>
6) Do you have any intolerance to hot or cold?	<input type="checkbox"/>	<input type="checkbox"/>
7) Do you have any bruising or bleeding disorders?	<input type="checkbox"/>	<input type="checkbox"/>
8) Have you had any skin changes, such as rashes or discoloration?	<input type="checkbox"/>	<input type="checkbox"/>
9) Have you experienced any changes in your vision, such as blurring, double vision, or decrease in your visual fields?	<input type="checkbox"/>	<input type="checkbox"/>
10) Have you had a recent episode of nausea/vomiting?	<input type="checkbox"/>	<input type="checkbox"/>
11) Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
12) Do you have osteoporosis? Date of your last bone scan:	<input type="checkbox"/>	<input type="checkbox"/>
13) Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>
14) Have you noticed any shortness of breath or decrease in exercise tolerance?	<input type="checkbox"/>	<input type="checkbox"/>
15) Do you use any assistive device? (i.e. cane, foot orthotics, walker)	<input type="checkbox"/>	<input type="checkbox"/>
16) Do you have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
17) Do you have any cardiac problems?	<input type="checkbox"/>	<input type="checkbox"/>
18) Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
19) Have you ever had cancer of any sort?	<input type="checkbox"/>	<input type="checkbox"/>
20) Do you have a history of neck or back problems?	<input type="checkbox"/>	<input type="checkbox"/>

Any other illness, past injuries I should be aware of? _____

Past surgeries: No Yes give brief details: _____

List the medications you are currently taking (over the counter/prescription): _____

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Social History

Are you presently working? Yes No Since: _____

Physical/Emotional demands of present occupation? (High, moderate, minimal) _____

Overall activity level: Sedentary Light Moderate Heavy Very heavy

Sports and Exercise (Type, Frequency, Duration) _____

Use of Tobacco: Yes No.

Use of Alcohol: Yes No.

Family medical History:

Does any one in your immediate family (mother, father, siblings) have a history of Diabetes, High Blood Pressure, Cardiac Problems, or Cancer? _____

Please list 3 goals of Physical Therapy and time frames:

- 1) _____
- 2) _____
- 3) _____

Who can we thank for this referral? _____

Thank you for completing these forms; we appreciate your input to help us help you!