

# HEALTH QUESTIONNAIRE FORM



Please check which clinic you will be attending therapy.  
Please remember to bring your picture ID and insurance cards.

- { } Belvidere Physical Therapy- Belvidere, IL      { } Marengo Physical Therapy- Marengo, IL  
{ } McHenry County Physical Therapy- McHenry, IL    { } Ogle County Physical Therapy- Byron, IL  
{ } Poplar Grove Physical Therapy- Poplar Grove, IL    { } Roscoe Physical Therapy- Roscoe, IL

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_  
(Last and suffix, i.e. Sr., Jr.)                      (First)                      (MI)

DOB: \_\_\_/\_\_\_/\_\_\_

Who referred you for physical therapy? \_\_\_\_\_

Please rate your general health status: (circle one)      **Excellent**      **Good**      **Fair**      **Poor**

Please describe the problem for which you seek physical therapy: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did the problem(s) begin (date)? \_\_\_\_\_

Is the problem related to a specific injury? \_\_\_\_\_

Please describe your pain: (circle one)      **Sharp**      **Dull**      **Constant**      **Periodic**

Is there anything that you do that relieves the pain? If so, what? \_\_\_\_\_  
\_\_\_\_\_

What movement or activities increase your pain? \_\_\_\_\_  
\_\_\_\_\_

Have you had this problem(s) before this episode? \_\_\_\_\_

If so, did the problem(s) get better? \_\_\_\_\_

How long did the problem(s) last? \_\_\_\_\_

Please list any special test(s) performed that relate to this problem(s) and the dates of the test(s):  
\_\_\_\_\_  
\_\_\_\_\_

Please list any medications you are currently taking: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Using the following scale, please mark your pain level at this time: **0= No pain**    **10= Emergency room pain**

0-----10

What type of exercise activities do you currently do and how often? \_\_\_\_\_  
\_\_\_\_\_

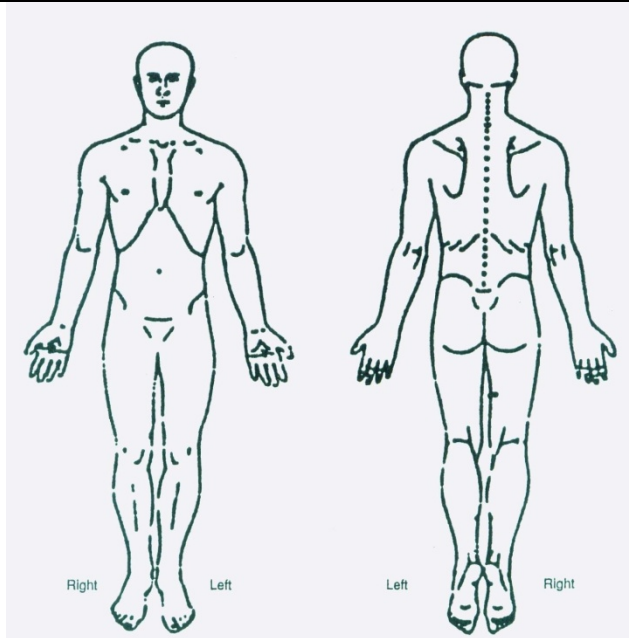
Is there any chance that you are pregnant? (circle one)    **Yes**    **No**

**Do you have a history of:**

	Yes	No		Yes	No		Yes	No
High Blood Pressure			Pacemaker			Respiratory Disorder		
Heart Condition			Seizures			Metal Implants		
Stroke			Cancer			Other Implants		
Diabetes			Falls			Other _____		
Dizziness			Other _____					

Using the following pictures, indicate where your pain is located. Using these symbols describe your type of pain:

Numbness === Aches ^^ ^ Pins/needles 000 Stabbing /// Burning XXX Cramping +++ Sharp \*\*\*



Are your symptoms affecting your ability to work or otherwise be active? \_\_\_\_\_ If so, how? \_\_\_\_\_

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Current limitations: (check all that apply)

- Difficulty with movement
- Changing positions in bed
- Walking:  level  stairs  ramps  uneven terrain
- Getting in and out of bed or up and down from a chair
- Difficulty with grooming and bathing

Difficulty with home management (household chores, yard work, driving, shopping): \_\_\_\_\_

Difficulty with community and work activities (work, school, play, recreation): \_\_\_\_\_

Patient/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by therapist: \_\_\_\_\_ Date: \_\_\_\_\_