

Homer Physical Therapy Patient Questionnaire

CONSENT: I understand that my diagnosis and treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered.

(Sign) _____ (Date) _____

Do you have any barriers to learning? Yes / No If "Yes", please list? _____

Gender: M/F Age: _____ Smoker: Y / N Pregnant: Y / N Occupation _____

Do you exercise at least 3 days per week? Y / N If so, what kind? _____

Date of Last Medical Checkup: _____ Past Surgical History (list & date): _____

Current Medications/Supplements: _____

Past Medical History: please circle each condition that you have been told you have (or had):

Cancer - If yes, what kind? _____ When? _____

Allergies - If yes, what kind? _____

Diabetes Kidney Disease Liver Disease Poor Balance (falls)

High Blood Pressure Heart Disease Angina/Chest Pain Ulcers Fibromyalgia

Osteoporosis Osteoarthritis Rheumatoid Arthritis Sexually Transmitted Disease

Asthma Lung Disease Have you had a recent illness? (Explain if yes) _____

Do you take blood thinners? Yes / No Are you allergic to latex? Yes / No

Other: _____

Currently I am experiencing (circle all that apply): Fever/Chills/Sweats Poor Balance (falls)

Unexplained Weight Loss Numbness or Tingling Changes In Appetite Difficulty Swallowing

Depression Shortness of Breath Dizziness Headaches

Changes in Bowel or Bladder Function Nausea/Vomiting Increased Pain at Night

How are you able to sleep at night? Fine ____ Moderate Difficulty ____ Only with Medication ____

Does your current complaint make sleep more difficult? _____

During the past month, have you often been bothered by feeling down, depressed or hopeless? Yes / No

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

What is your Main Complaint? _____

What is your Secondary Complaint? _____

When did your pain begin? _____ How (gradually, suddenly)? _____

Is your pain/condition related to - (circle what applies) Non-work New Injury Pre-Operative Post-Surgical

Exacerbation of pre-existing injury Re-occurrence of Pre-existing Injury Sports

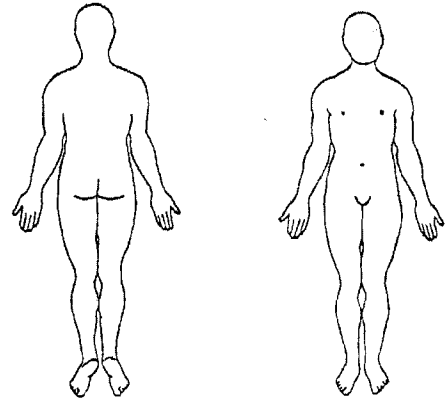
My symptoms are currently (circle one): Getting better / About the same / Getting worse

What treatments have you received for this problem so far? Primary Physician Chiropractic OT PT Orthopedic

Surgeon Neurologist Massage Acupuncture Gynecologist Exercise Bed Rest Ice Heat Medication General

Surgeon Other _____

Body Chart: Please mark the areas on the chart where you feel pain.



Have you had any of the following for this complaint?

X-Ray MRI CT Scans(CAT) Doppler Study Ultrasound Other _____

On the scale below, place a **C** over current pain level; a **W** over worst pain level; a **B** over best pain level:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

On the scale below, please circle the number which best represents your level of function:

Cannot do Anything 0 1 2 3 4 5 6 7 8 9 10 Able to Do Everything

What are 3 activities you can not perform due to pain?

- 1 _____
- 2 _____
- 3 _____

Are you currently able to work? Yes No Light duty Modified duty

If you are not working, when was your last day of work: _____

What are your personal goals for therapy at this time?

- 1 _____
- 2 _____
- 3 _____

Please read carefully our policies regarding your treatment:

1. You are expected to participate in your own care. If you do not keep your scheduled appointments, accept the limitations that have been placed on you by your physical therapist and follow through with your Home Exercise Program, it could lead to a premature discharge.
2. Be honest with your therapist. In order for you to receive the best care, your therapist needs to know what you have been doing and how you feel.
3. If you are more than 15 minutes late for your appointment, it will be considered a No-Show. You will be billed accordingly.

Signature _____ Date _____