



PATIENT QUESTIONNAIRE

Patient's Name: _____

DOB: _____

1. Occupation: _____

2. How did your problem begin?

- Motor vehicle accident
- Post surgical
- Work-related injury
- Sports / training injury
- Recent injury with unknown cause
- Chronic illness / condition
- Other _____

3. Have you received previous physical or occupational therapy for this condition?

Comments? _____

4. Have you seen any of the following medical professional in the past 3 months?

- Medical Doctor (M.D.) Yes No
- Osteopathic Doctor (D.O.) Yes No
- Dentist Yes No
- Psychiatrist / Psychologist Yes No
- Physical Therapist Yes No
- Chiropractor Yes No

5. Describe the reason for seeing any of the above if checked: _____

6. Recent Tests: Blood tests X-ray CT Scan MRI EMG Bone Scan

7. Have you EVER been diagnosed as having the following conditions?

- | | | | |
|----------------------------|--|---------------------------------|--|
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack / Cardiac Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Multiple Sclerosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other Arthritic Conditions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy or Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

8. List any surgeries or conditions for which you have been hospitalized (include reason and date)

Date	Surgery / Reason for hospitalization
_____	_____
_____	_____
_____	_____
_____	_____

9. List any history of injuries or accidents (fractures, dislocations, sprains, etc.) and approximate dates

10. List any prescription medications you are currently taking (include oral, injections, skin patches, etc.)



11. Which of the following OVER-THE-COUNTER medications have you taken in the past week?

- | | | | | | |
|-------------------------------|------------------------------|-----------------------------|----------------|------------------------------|-----------------------------------|
| Aspirin | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tylenol | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Advil / Motrin / Ibuprofen | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Laxatives | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Decongestants | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Antihistamines | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Vitamin / Mineral Supplements | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other | <input type="checkbox"/> Yes | <input type="checkbox"/> No _____ |

12. How many cups of caffeinated coffee or other caffeinated beverages do you drink per day? _____

13. If you are a smoker, how many packs of cigarettes do you smoke a day? Or cigars? _____

0 ½ 1 1½ 2 More than 2

14. How many days per week do drink alcohol?

0 1 2 3 4 5 6 7