TOKHEIM-CORBETT PHYSICAL THERAPY

Health History Questionnaire

NAME:_____DATE:_____

1. **Briefly describe your present symptoms/injury**: _____

2. **When did your symptoms begin (approximately)?** DATE: _____/_____/_____

3. **Were your symptoms caused by a specific trauma or injury?** YES/NO
   If yes, explain: _____

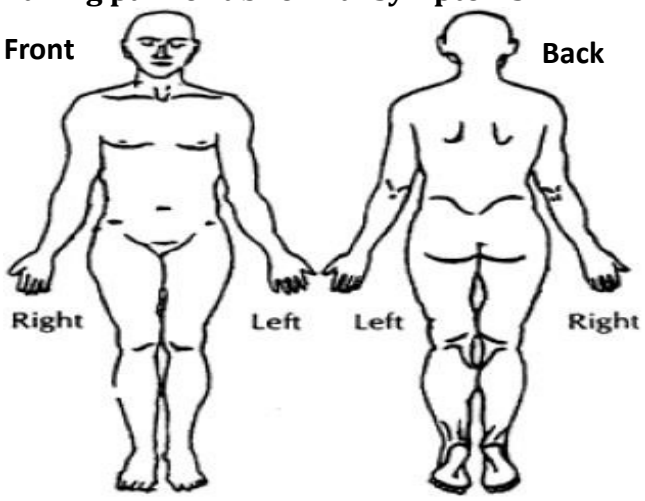
4. **Have you had similar symptoms in the past?** YES/NO
   If yes, explain: _____

5. **Did you have surgery?** YES/NO If yes, describe _____ DATE: _____/_____/_____

6. **Numeric Pain Rating Scale:** Circle **one** number for each scale below. Rate your pain level at:
   (0=no pain, 10=extreme/severe pain)

WORST:	0	1	2	3	4	5	6	7	8	9	10
CURRENT:	0	1	2	3	4	5	6	7	8	9	10
BEST:	0	1	2	3	4	5	6	7	8	9	10

7. **Use an "X" symbol to mark where you are having pain or abnormal symptoms.**



8. **How would you describe your pain?** (check those that apply)
   - ☐ Sharp
   - ☐ Dull/Achy
   - ☐ Shooting
   - ☐ Numb/Tingling
   - ☐ Burning
   - ☐ Throbbing
   - ☐ Other: _____

9. **Does your problem affect your sleep?** YES/NO

10. **Since they began, are your symptoms getting…**
    - ☐ Better
    - ☐ Worse
    - ☐ Same

11. **What activities AGGRAVATE your symptoms?** (check those that apply)

☐ Sitting	☐ Stairs	☐ Reaching	☐ Deep breath
☐ Standing	☐ Bending	☐ Twisting	☐ Eating
☐ Walking	☐ Cough/Sneeze	☐ Sit to Stand	☐ Other:_____

12. **What helps EASE your symptoms?** (check those that apply)

☐ Sitting	☐ Walking	☐ Heat
☐ Standing	☐ Lying Down	☐ Medication
☐ Rest	☐ Ice	☐ Other:_____

13. **When are your symptoms best?**

☐ Morning	☐ Afternoon	☐ Evening	☐ No change

Signature_____Date: _____

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Health History Questionnaire

NAME:_____DATE:_____

14. Have you had a fall in the last year? YES/NO If yes, were you injured from the fall? YES/NO

15. Have you had two or more falls in the past year? YES/NO

16. Have you had any of the following since the onset of your symptoms?

- ☐ Change in bowel/bladder
- ☐ Night pain/sweats
- ☐ Unexplained weight loss/gain
- ☐ Fever or chills
- ☐ Numbness/tingling
- ☐ Dizziness or fainting spells
- ☐ Weakness
- ☐ Malaise
- ☐ Problems with vision/hearing

Explain:_____

17. Personal Medical History (please check all that apply)

- ☐ Cancer
- ☐ Liver/Kidney Problems
- ☐ Thyroid Problems
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Hypertension
- ☐ Circulation problems
- ☐ Lung disease
- ☐ Heart disease
- ☐ Asthma
- ☐ Allergies
- ☐ Neurologic disorders
- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Stomach problems
- ☐ Fibromyalgia
- ☐ Pacemaker
- ☐ Current Infection
- ☐ Infectious Disease
- ☐ Depression
- ☐ Mental/Behavioral Disorder
- ☐ Broken Bone
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Alzheimer's
- ☐ Other_____

Explain: _____

18. Have you received ANY other treatment for this problem? YES/NO List:_____

19. Please list ALL previous surgeries and date: _____

20. How often do you exercise?

- ☐ Seldom/Never
- ☐ 1-2 times per week
- ☐ 3+ times per week

21. Do you smoke? YES/NO How much? _____ **22. Are you pregnant?** YES/NO

23. Have you had any of the following tests for this condition?

- ☐ X-ray
- ☐ MRI
- ☐ CT Scan
- ☐ Other: _____

24. List all current prescription medications and dosages: _____

_____

25. Are you taking any of the following over the counter medications/vitamins?

- ☐ Tylenol
- ☐ Advil/Ibuprofen/Motrin
- ☐ Aspirin
- ☐ Antihistamine
- ☐ Corticosteroid
- ☐ Vitamins/Minerals/Supplements
  - o Vitamin D? YES/NO Dosage _____
- ☐ Other: _____

26. List 3 of your normal activities that you are now limited in performing due to this problem.

1. _____ 2. _____ 3. _____

Signature_____Date: _____