PATIENT HISTORY QUESTIONNAIRE

South Lane Physical Therapy LLC

PLEASE FILL OUT THIS FORM AS COMPLETE AS POSSIBLE. IT WILL ASSIST YOUR THERAPIST IN DEVELOPING A PLAN OF CARE FOR YOU. IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO ASK FOR ASSISTANCE. THIS INFORMATION WILL REMAIN CONFIDENTIAL UNLESS AUTHORIZED FOR RELEASE BY THE PATIENT.

NAME _____ DATE OF BIRTH: _____

OCCUPATION _____ HOBBIES: _____

DATE OF INJURY _____ PLEASE CIRCLE: SUDDEN ONSET GRADUAL ONSET

HAS THIS INJURY PREVENTED YOU FROM WORKING? YES NO IF YES, HOW LONG OFF WORK_____

WORK STATUS: AT THE PRESENT TIME I AM ABLE TO:

_____ Work without restrictions
_____ Work the same job with restrictions
_____ Work a different job with restrictions
_____ Unable to work due to dysfunction
_____ Don't normally work outside the home
_____ Homemaker
_____ Retired
_____ Other

IS AN ATTORNEY INVOLVED WITH THE CASE? YES NO

IF YES, ATTORNEY NAME: _____ PHONE: _____

HAVE YOU SOUGHT PREVIOUS TREATMENT FOR THIS CONDITION?

_____ No other treatment _____ Massage Therapy _____ Chiropractor
_____ Physical/Occupational Therapy _____ Psychiatrist/Psychologist _____ Other: _____

LIST ALL PRESCRIPTION MEDICATION YOU ARE TAKING (Including injection and skin patches: _____

_____

_____

LIST ALL OVER-THE-COUNTER MEDICATIONS YOU ARE TAKING (Including vitamins and supplements):

_____

_____

PLEASE LIST ANY SURGERIES OR OTHER CONDITIONS FOR WHICH YOU HAVE BEEN HOSPITALIZED:

DATE	SURGERY/HOSPITALIZATION	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____

ARE YOU CURRENTLY HAVING OR HAVE EXPERIENCED ANY OF THESE SYMPTOMS IN THE PAST 3 MONTHS?

_____ Fever _____ Chills _____ Night Sweats _____ Shortness of Breath
_____ Pins/Needles _____ Numbness _____ Skin Rash _____ Headaches
_____ Vision Problems _____ Hearing Loss _____ Bowel/Bladder Problem

PLEASE CHECK ALL THE FOLLOWING CONDITIONS THAT APPLY TO YOU EITHER PRESENTLY OR IN THE PAST

_____ High Blood Pressure _____ Epilepsy/Seizures _____ Gout _____Varicose Veins
_____ Chest Pain/Heart Attack _____ Kidney Disease _____Hepatitis _____ Dizziness/Fainting
_____ Stroke _____Asthma _____Arthritis _____Depression
_____ Heart Disease _____ Emphysema/Bronchitis _____ Tuberculosis _____Lung Disease
_____ Cardiovascular Disease _____ Hearing Loss _____Thyroid _____Overweight/obesity
_____Emotional/Psychological Problems _____Chemical Dependency (alcohol/drugs)
_____ Allergies: _____
_____ Other: _____

HAS ANYONE IN YOUR IMMEDIATE FAMILY (Parents, Brothers, Sisters) EVER BEEN TREATED FOR ANY OF THE FOLLOWING?

_____ Cancer _____Heart Disease _____Diabetes _____ Tuberculosis _____ Mental Disorder
_____ Arthritis _____ High Blood Pressure _____ Kidney Disease _____Stroke

HAVE YOU RECENTLY EXPERIENCED ANY SIGNIFICANT CHANGES IN:

_____ Mood _____ Energy level (restlessness, lethargy, or fatigue)
_____ Interest or pleasure in daily activities _____Recurrent thoughts of death or harming yourself
_____ Loss/Gain of appetite or weight loss/gain _____Sleeping habits

How many packs of cigarettes do you smoke per day? _____
How many days per week do you drink alcohol?_____ How much do you drink at an average sitting?_____
Are there any other substances that you regularly use?_____

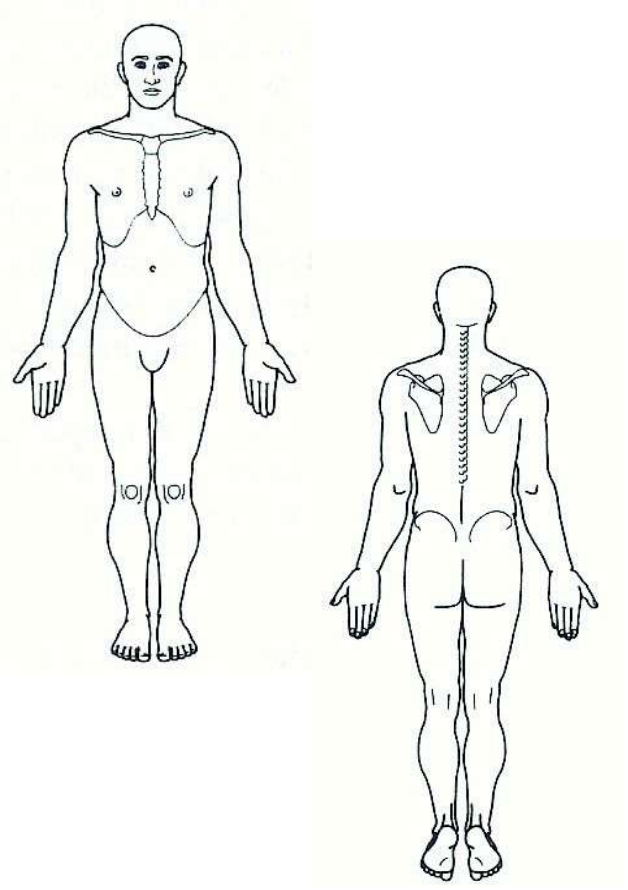
ARE YOU AWARE OF YOUR DIAGNOSIS? YES NO

DO YOU HAVE QUESTIONS REGARDING YOUR DIAGNOSIS OR PROGNOSIS?

RATE YOUR AVERAGE DISCOMFORT ON THE SCALE BELOW

0 _____ 10
(no pain) (severe pain)

PLEASE MAP YOUR AREAS OF DISCOMFORT OR ALTERED SENSATION ON THE BODY MAP:
XXX = Pain 000 = Numb/Tingle *** = Weakness



OTHER COMMENTS OR CONCERNS YOU MAY HAVE:

_____

_____

_____

Form reviewed by therapist:
_____ (PT initials) _____(Date)