PEAK PERFORMANCE
SPORTS & SPINE ◆ PHYSICAL THERAPY

Patient Health History Questionnaire

Patient Name _____ **Date of Birth** _____ **Today's Date** _____

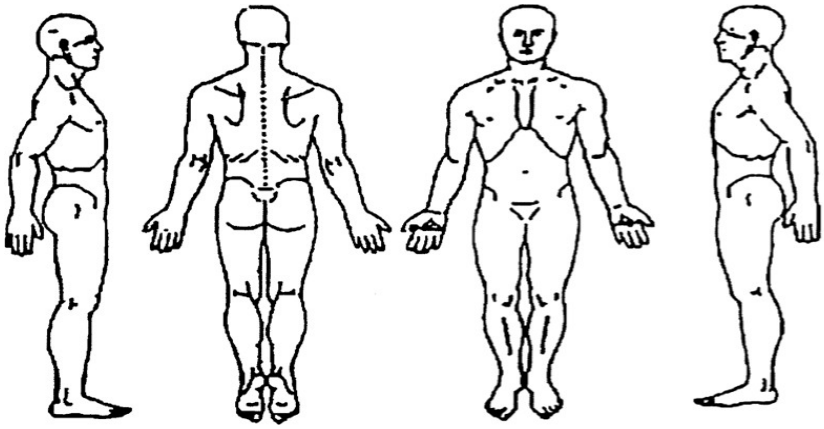
Date of Injury/ Onset: _____ **Duration of Symptoms**: _____

Are you currently experiencing pain? ☐ Yes ☐ No

Indicate the areas of pain on the following diagram:

Describe the pain:

- ☐ Sharp
- ☐ Burning
- ☐ Pain
- ☐ Numbness
- ☐ Pulsating



Please circle the number that indicates your worst level of pain when doing activity today.

NO Pain — 0 1 2 3 4 5 6 7 8 9 10 — Worst Pain imaginable

Diagnostic tests related to the current condition:

- ☐ Bone scan
- ☐ CT scan
- ☐ Labs
- ☐ MRI
- ☐ NCV/EMG
- ☐ Ultrasound
- ☐ X-ray
- ☐ Other: _____

Are you experiencing any of these conditions related to your current problem/complaint? ☐ Yes ☐ No

If yes, please specify:

- ☐ Chest pain or pressure
- ☐ Bowel/bladder function difficulties
- ☐ Dizziness/fainting
- ☐ Fever/chills
- ☐ Headaches
- ☐ Nausea/vomiting
- ☐ Night sweats/night pain
- ☐ Numbness in the genital/ anal area
- ☐ Pregnant? # of weeks ___
- ☐ Problems with vision, hearing and speech.
- ☐ Under doctor's care
- ☐ Unexplained shortness of breath
- ☐ Unexplained weakness
- ☐ Unexplained weight change
- ☐ Other: _____

Continue to page 2…

Fall Assessment: Have you had two (2) or more falls in the last 12 months? ☐Yes ☐No

Have you had **any** falls in the past 12 months? ☐Yes ☐No

Allergies: Are you allergic/sensitive to latex or adhesive? ☐Yes ☐No

Do you have any other allergies? ☐Yes ☐No

If yes, please list: _____

Please indicate any previous surgeries or medical conditions:

Condition/Surgery:	**Description**
☐ Cancer	
☐ Cardiac	☐ High Blood Pressure ☐ Heart Attack ☐ Congestive Heart Disease
☐ Endocrine	☐ Diabetes ☐ Thyroid condition
☐ Genitourinary	
☐ Infection	
☐ Neurological	☐ Stroke ☐ Seizures ☐ Multiple sclerosis
☐ Orthopedic	☐ Osteoporosis
☐ Pulmonary	
☐ Reproductive	
☐ Implanted devices	☐ Pacemaker ☐ Nerve stimulator ☐ Pumping device ☐ Deep Brain Stimulator
☐ Other	

Home environment:

☐ Indoor stairs with railing? *How many?* ___

☐ Indoor stairs without railing? *How many?* ____

☐ Outdoor stairs with railing? *How many?* ___

☐ Outdoor stairs without railing? *How many?* __

Employment status: Occupation, if applicable:_____ Hours/Week: _____

☐ Full time Part time

☐ Part Time

- ☐ *Work without restrictions*
- ☐ *Working same job with restrictions*
- ☐ *Working different job with restrictions*

☐ Retired

☐ Disabled

☐ Unemployed

- ☐ *Unable to work due to current condition*

Social History: Tobacco Use: ☐ Never ☐ Previously, but quit ☐ Yes, # per day: _____

Alcohol Use: ☐ Never ☐ Previously, but quit ☐ Yes, # per day: _____

Drug Use: ☐ Never ☐ Previously, but quit ☐ Yes, # per day: _____

By signing your name below, you agree that the information provided is true to the best of your knowledge.

Patient Signature: _____ **Date:** _____

For office use only

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