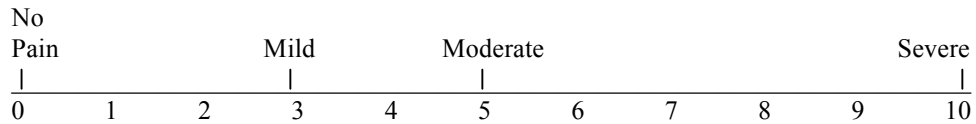


Date: _____

Specific Date of Onset: _____

Please indicate where your present pain level is by circling the number that best describes the intensity:



Your insurance company may inquire as to how your pain/dysfunction is currently interfering with your daily activities. **Please 1) Indicate specific activity limitations that you have currently. You may report in minutes, hours, distance, etc. for activities limited at this time. If a listed activity is not limited leave blank. You may “add” activities under recreational activities and other. 2) Please list any activities that you had limitations with prior to the onset of this occurrence of pain, injury or surgery in area titled Limitations prior to this problem.**

1. <u>Current:</u>	How much/long before limiting?	Can't Do		How much/long before limiting?	Can't Do
Standing	_____	_____	Bathing	_____	_____
Sitting	_____	_____	Eating	_____	_____
Walking	_____	_____	Dressing	_____	_____
Stairclimbing	_____	_____	Using toilet	_____	_____
Sleeping	_____	_____	Writing	_____	_____
Driving	_____	_____	Computer work	_____	_____
Lifting	_____	_____	Combing/ Fixing hair	_____	_____
To waist	_____	_____	Reaching back pocket	_____	_____
Lifting	_____	_____	Housekeeping	_____	_____
overhead	_____	_____	Opening Doors	_____	_____
Bending to	_____	_____	Applying makeup Or shaving	_____	_____
Tie shoes	_____	_____	Other (list):	_____	_____
Turning car Ignition	_____	_____	_____	_____	_____
Opening Containers	_____	_____	_____	_____	_____
Recreational Activities:	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

2. Prior Limitations prior to this problem: _____

Therapist Use Only: _____

History reviewed by Therapist

Date

**Hendricks Regional Health
Physical & Occupational Therapy
Patient Questionnaire**

Please complete *all pages* of the following questionnaire, as this will assist your therapist in evaluating you. Should you need assistance, please ask the office staff. If you do not fill out this questionnaire, the therapist will have to spend your evaluation time completing it with you. **Thank you!**

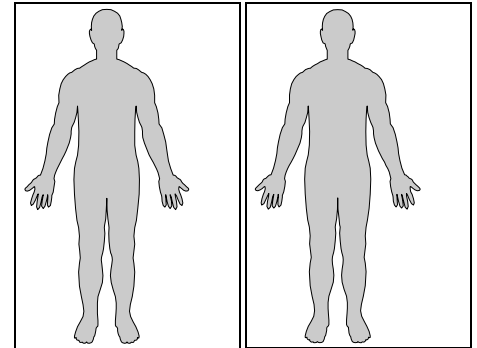
Name _____ Date _____

R L hand dominant Age: _____ If less than 18 years old: Height: _____ Weight: _____

1. What is your reason for attending therapy?

2. Please use the diagram at the right to show your location of pain/problem in the last 24 hours. Use a P to mark pain and an N to mark numbness and/or tingling:

3. My specific goals upon completion of therapy are: (how will you know you are better?)



4. Have you had an accident/injury related to this problem? no yes If yes, please describe:

5. When did your problem/pain begin (date; mm/dd/yy if possible): _____
a. If more than 6 months, have you had a recent flare up of your symptoms, please explain and give date:

b. Frequency /Duration: Constant Frequent Occasional _____
c. How would you describe your pain? Not Applicable Sharp Dull Burning Other _____

6. What symptoms did you first notice: _____

7. What activities or positions increase your complaints?

8. What activities or positions decrease your complaints? _____

9. Are your complaints getting: Better Worse Staying the same?

10. Have you had this problem before? no yes, please explain: _____

11. Any difficulties with bowel or bladder function related to this problem? No Yes, please explain

12. Any dizziness or unsteadiness on your feet? No Yes, explain

13. Does coughing/sneezing aggravate your complaint? No Yes, explain

**Hendricks Regional Health
Physical & Occupational Therapy
Patient Questionnaire**

14. Do you have any difficulty swallowing? no yes, please explain: _____

15. Check any previous treatments for this problem:

<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Social Service	<input type="checkbox"/> Support Group
<input type="checkbox"/> Dietary Consult	<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> First Steps
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Splinting	<input type="checkbox"/> Surgery (date) _____
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Injection	<input type="checkbox"/> Other _____

16. Any X-rays, MRI, CT, EMG, etc. taken related to your current problem? yes no
If yes, results (include date and where taken) _____

17. Are you currently working? yes no unemployed with limitation on disability
Comment/restrictions given by doctor: _____

18. Is there a Workman's Comp. or lawsuit pending regarding your problem?
 yes no comment _____
Name of Workman's Comp. Caseworker _____

19. Occupation: _____
What does your job involve:
_____ % Sitting; circle all that apply: computer, assembly line, desk work
_____ % Driving; type of vehicle: _____
_____ % Standing; surface: _____
_____ % Lifting; range of weight lifted: _____
Number of times per hour: _____ From _____ to _____ (heights)
_____ % Other: _____

20. Past History of Injuries/Accidents : _____	Past Surgical History : _____
Year Description	Year Description
_____	_____
_____	_____

21. Other Medical: Have you ever been diagnosed with any of the following conditions?	Associated Medication
Arthritis <input type="checkbox"/> No <input type="checkbox"/> Yes, Date/Comment: _____	_____
Osteoporosis <input type="checkbox"/> No <input type="checkbox"/> Yes, Date/Comment: _____	_____
Cancer <input type="checkbox"/> No <input type="checkbox"/> Yes, Date/Comment: _____	_____
Heart disease <input type="checkbox"/> No <input type="checkbox"/> Yes, Date/Comment: _____	_____
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, Date/Comment: _____	_____
Circulation problems <input type="checkbox"/> No <input type="checkbox"/> Yes, Date/Comment: _____	_____
Chemical dependency <i>(i.e. drug, alcohol, etc.)</i> <input type="checkbox"/> No <input type="checkbox"/> Yes, Date/Comment: _____	_____
Stomach disorders <input type="checkbox"/> No <input type="checkbox"/> Yes, Date/Comment: _____	_____
Lung disease <input type="checkbox"/> No <input type="checkbox"/> Yes, Date/Comment: _____	_____
Thyroid disease <input type="checkbox"/> No <input type="checkbox"/> Yes, Date/Comment: _____	_____
Hepatitis <input type="checkbox"/> No <input type="checkbox"/> Yes, Date/Comment: _____	_____
Kidney/bladder disease <input type="checkbox"/> No <input type="checkbox"/> Yes, Date/Comment: _____	_____
Skin disease <input type="checkbox"/> No <input type="checkbox"/> Yes, Date/Comment: _____	_____
Epilepsy <input type="checkbox"/> No <input type="checkbox"/> Yes, Date/Comment: _____	_____
High blood pressure <input type="checkbox"/> No <input type="checkbox"/> Yes, Date/Comment: _____	_____
Female/Male diseases <input type="checkbox"/> No <input type="checkbox"/> Yes, Date/Comment: _____	_____
Neurological <input type="checkbox"/> No <input type="checkbox"/> Yes, Date/Comment: _____	_____
Depression <input type="checkbox"/> No <input type="checkbox"/> Yes, Date/Comment: _____	_____
Are you pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes, Date/Comment: _____	_____
Other <input type="checkbox"/> No <input type="checkbox"/> Yes, Date/Comment: _____	_____

**Hendricks Regional Health
Physical & Occupational Therapy
Patient Questionnaire**

22. List any additional medications or alternative medicines you are currently taking (over the counter & prescription):

23. Please list any allergies (including allergy to Latex):

24. Have you ever reacted to the following when handling, or after eating, avocados, bananas, tropical fruit, pineapple, kiwi, nectarines, peaches, cherries, chestnuts, poinsettia plants, balloons, elastic bandages or rubber products?
 yes no
25. Do you have, or have you had in the past; eczema on your hands, unexplained anaphylaxis (acute extreme shortness of breath, cardiac arrest or shock-sudden drop of blood pressure), or did you have multiple surgical procedures during infancy? yes no
26. Have you been on cortisone/prednisone? No Yes, when? _____
27. Do you Smoke? No Yes, how much?

28. Do you drink caffeine? No Yes, how much?

29. Do you drink alcohol? No Yes, how much? _____
30. Why did you choose this facility for your service? (**Check all that apply**)
 Reputation of Clinic Insurance Requirement My physician's recommendation
 Location Friend's or family's recommendation Other: _____
31. I desire to learn : (**Check all that apply**)
 exercises injury prevention ergonomics (fit the job to the person)
 posture correction additional resources that may help me
32. I prefer to learn in the following ways:
 demonstration verbal instruction video written material
33. Difficulty with writing? yes, related to this problem yes, unrelated to this problem no
 comment _____
Difficulty with reading? yes no comment _____
34. My primary language is: English Spanish other _____
35. Check current or prior conditions that you may have or had:
 language impairment emotional disorder mental disorder; type _____
 vision impairment cognitive disorder communicative disorder
 hearing impairment physical impairment developmental disabilities
Comments: _____
36. When is your next doctor's appointment for this problem? _____
37. Did your doctor give you any limitations regarding this problem? If yes, please list/explain: _____

38. Is there any other information you feel might be helpful for the therapist to know before your evaluation? If yes, please explain: _____

