CHOOSE THE HOME TEAM CYPRESS CREEK THERAPY

Physical & Occupational Therapy Patient Questionnaire

Patient Name: _____ Date of Birth: _____

Height: Feet: ___ Inches: ____ Weight: _____

REASON FOR VISIT
CHIEF COMPLAINT

Please briefly describe the reason for this visit:

When did the problem begin (date) Month_____ Year _____

Please rate the severity of your pain/symptoms by circling the appropriate number on a scale of 0 to 10 with 0 being no pain/symptoms and 10 being severe pain/symptoms

Pain at worst: 0 1 2 3 4 5 6 7 8 9 10

Pain at best: 0 1 2 3 4 5 6 7 8 9 10

Pain currently: 0 1 2 3 4 5 6 7 8 9 10

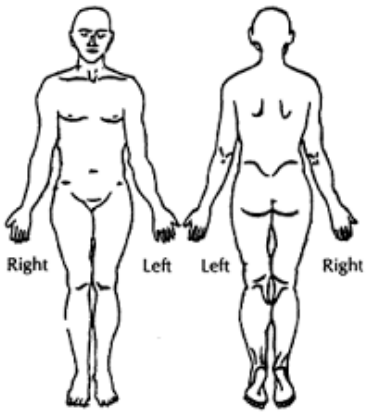
When is it the worst? (Please circle all that apply):
Morning Evening Constant Standing Sitting Walking Driving
Other_____

What makes the problem better?_____

How would you describe you symptoms (please circle all that apply): Aching Burning Dull Sharp Numbness Tingling Throbbing Spasms Tightness

Other:_____

Please shade area(s) on diagram below the location of you problem/pain:



Medical History	Please check ***all*** illnesses or conditions which apply to you: ☐ Anemia ☐ Diabetes ☐ Kidney Disease ☐ Asthma ☐ Mental Illness ☐ Kidney Stones ☐ Arthritis ☐ Emphysema ☐ Liver Disease ☐ Bleeding/Blood Disorder ☐ Epilepsy/seizures ☐ Multiple Sclerosis ☐ Cancer(s)_____ ☐ Fibromyalgia ☐ Osteoporosis ☐ Cataracts ☐ Glaucoma ☐ Rheumatic Fever ☐ Chronic fatigue syndrome ☐ Heart disease ☐ Thyroid disease ☐ Chronic pain syndrome ☐ Hepatitis/jaundice ☐TMJ/jaw problems ☐ Colitis ☐ High Blood Pressure ☐ Tuberculosis ☐ Depression ☐ HIV/AIDS ☐ Ulcers ☐ Other(s): _____
Trauma & Serious Injuries	Please list below any *prior* serious injuries you have sustained and their approximate dates: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____
Surgeries Hospitalizations	Please list any *prior* surgeries with approximate date(s): 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____
Recent Tests	Please list below any recent tests you have had. (ex. Xray, MRI, nerve conduction study) 1. _____ DATE_____ 2. _____ DATE_____ 3. _____ DATE_____ 4. _____ DATE_____
Allergies	Are you allergic to tape? ☐ Yes ☐ No Are you allergic to latex? ☐ Yes ☐ No Please list any other allergies: _____

Medications

Please list ***all*** medications you are currently taking including any herbal medications, vitamins or supplements that you take: (Include: name, dose, frequency, and route of intake)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Social History and Habits

Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

What is your **smoking** status? ☐ Never ☐ Past ☐ Current; Frequency:_____

Do you drink? ☐ No ☐ Yes How many drinks/ week _____

Exercise

How many days per week do you exercise for at least 30 minutes: ☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6-7

☐ Walking ☐ Biking ☐ Aerobics ☐ Exercise equipment ☐ Running

☐ Swimming ☐ Weights ☐ Organized sports

Other: _____

Falls

Have you had any falls in the past year? ☐ No ☐ Yes Number: _____

Have any of your falls resulted in major injuries? ☐ No ☐ Yes, Explain _____

Review of Symptoms

Please review the following list of symptoms and check ***all*** that apply to you:

Head and Neck Symptoms:

- ☐ Visual changes (not glasses)
- ☐ Double vision
- ☐ Dizziness
- ☐ Vertigo
- ☐ Sinus problems
- ☐ Ear pain
- ☐ Trouble hearing
- ☐ Ringing in the ear
- ☐ TMJ or jaw pain

Musculoskeletal Symptoms:

- ☐ Joint pain
- ☐ Back pain
- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Arm pain
- ☐ Leg pain
- ☐ Foot pain
- ☐ Ankle pain
- ☐ Elbow pain
- ☐ Weakness in arms/legs
- ☐ Joint swelling or stiffness
- ☐ Scoliosis

Neurologic Symptoms:

- ☐ Numbness or tingling
- ☐ Severe and/or frequent headaches
- ☐ Abnormal coordination
- ☐ Trouble with speech
- ☐ Forgetfulness
- ☐ Confusion

Heart/Vascular Symptoms:

- ☐ Chest pain or pressure
- ☐ Irregular rapid heart beat