HIGHLINE PHYSICAL THERAPY

INITIAL QUESTIONNAIRE AND MEDICAL HISTORY

Name:

Age:

Date:

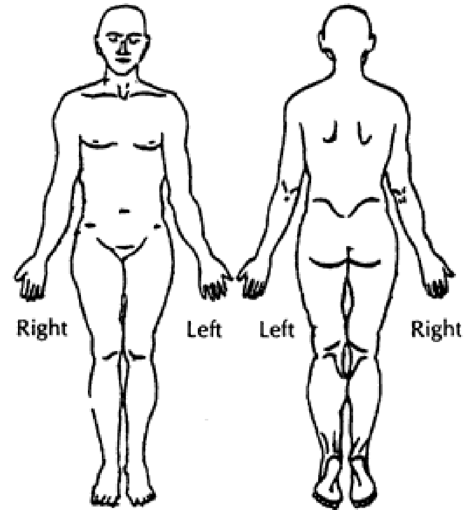
What is the reason for your visit today?			
Date of injury/onset of symptoms:		Date of surgery (if applicable):	

Where did your injury occur? Work Auto Home NA-Gradual onset Other:

Which best describes how your injury occurred?

Cumulative trauma/overuse	MVA
Degenerative process	Sports/Recreation
Fall	Trauma
Lifting	Unknown/Gradual onset

Shade areas of pain or discomfort on the figure below



Since onset, are your symptoms: (circle one)

Improving Worsening Not changing

Frequency of symptoms: (circle one)

Constant Intermittent/Daily Occasional

Nature of symptoms. Circle all that apply.

Burning	Sharp
Dull/Achy	Shooting
Numbness/Tingling	Throbbing

When is your pain the worst?

Morning Evening Neither

Please rate your pain on a scale of 0 to 10: At Present: ____ Lowest (last 24 hours):____ Highest (last 24 hours):____

0 = no pain 1, 2, 3 = low pain 4, 5, 6 = moderate pain 7, 8, 9 = intense pain 10 = emergency

What aggravates your symptoms? Circle all that apply.

Coughing/Sneezing	Lifting	Repetitive activities	Stress
Driving	Looking up overhead	Running	Sustained bending
Getting dressed	Reaching behind back	Sitting	Taking a deep breath
Going to/rising from sitting	Reaching out from body	Sleeping	Walking
Household activities	Reaching overhead	Stairs	
Kneeling/Squatting	Recreation/Sports	Standing	

Do your symptoms wake you up at night? NO YES. If yes, how often?

If yes, do you wake: While lying still Only when changing positions Both

What activities at home, work, or recreational are you unable to perform because of this injury/condition?

What relieves your symptoms? Circle all that apply.

Changing positions	Heat	Rest	Stretching
Cold	Massage	Sitting	Walking
Exercise	Medication	Splint/Brace wear	Nothing relieves my symptoms

Since the onset of your current symptoms, have you experienced any of the below? Circle all that apply.

Abdominal pain	Dizziness/Lightheadedness	Heart burn/Indigestion	Persistent cough
Bowel/Bladder changes	Fainting	Muscle weakness	Recent infection
Difficulty swallowing	Fever/Chills/Sweats	Nausea/Vomiting	Unexplained weight loss
Difficulty walking	Headaches	Night pain	Vision changes

Have you had any of the below tests for this condition? Circle all that apply.

X-ray	MRI	FCE/IME	Test results if known:
Arthrogram	CT scan	Other:	

Please indicate any previous or current treatment you have had related to your current injury. Circle all that apply.

Chiropractic/Osteopath	Massage Therapy	Occupational Therapy	Other:
Injection	Medication	Physical Therapy	None

PLEASE COMPLETE OTHER SIDE

Patient Name:___________________________________

WORK HISTORY		
Are you currently employed?	YES NO Retired Student	
Occupation:		
If injured on the job or work is affected by your current symptoms, please fill out next 3 questions.		
Are you currently working?	YES/Full Duty YES/Light Duty NO. Last day of full duty:	
Are you planning to return to your job of injury?	YES NO Unsure	
If no, has an alternate job goal been identified for you?	NO/I don't know YES, the new goal is:	

MEDICAL HISTORY	
At the present time, would you say that your health is:	Excellent Good Fair Poor

Please indicate if you have had any prior injuries to the following joints. Circle all that apply.

Ankle Back Elbow Foot Hand Hip Knee Neck Shoulder Wrist

Please indicate if you have had or currently have any of the below medical conditions. Circle all that apply.

Allergies	Face/Ear/Jaw pain	Kidney disease	Pregnant (currently)
Anemia	Fibromyalgia	Latex or tape allergy	Reflux/GERD
Asthma	Gout	Liver disease	Rheumatoid arthritis
Back/Neck pain	Heart disease	Migraines	Shortness of breath
Blood clots	Hepatitis	Multiple Sclerosis	Skin condition
Cancer	Hernia	Osteoarthritis	Stroke /TIA
Chest pain	High blood pressure	Osteoporosis	Swelling in feet/legs
Depression	HIV+/AIDs	Pacemaker	Thyroid issues
Diabetes	Imbalance	Parkinson's	Tuberculosis
Epilepsy/Seizures	Incontinence	Polio	

Please list any other medical conditions we should know about:

Please list any surgeries you have had:

Have you had any major illnesses/hospitalizations in the last year? NO YES. If yes, please describe below.

MEDICATIONS: Please list all medications you are taking including dosage, frequency and route of administration. Include all prescriptions, over-the-counter, herbal/vitamin/mineral supplements. Please complete to the best of your ability. If you have a list, please give it to our front office staff so that they may make a copy.

□ Please see attached list □ I am not taking any medications, vitamins or supplements

Name	Dosage	Frequency	Route of administration
		1 2 3 4x/day PRN	Oral Injection Other
		1 2 3 4x/day PRN	Oral Injection Other
		1 2 3 4x/day PRN	Oral Injection Other
		1 2 3 4x/day PRN	Oral Injection Other
		1 2 3 4x/day PRN	Oral Injection Other
		1 2 3 4x/day PRN	Oral Injection Other
		1 2 3 4x/day PRN	Oral Injection Other
		1 2 3 4x/day PRN	Oral Injection Other
		1 2 3 4x/day PRN	Oral Injection Other

Have you had any falls in the past 12 months?	YES NO		
If yes, how many?		**Did you injure yourself in any of those falls?**	YES NO
Do you currently use any type of tobacco products?	YES NO		

____ _______________________

Patient or Guardian Signature **Date**

For office use only: **Heart Rate:**__________ **Blood Pressure:**_________ **Taken by:**___________________________