



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):

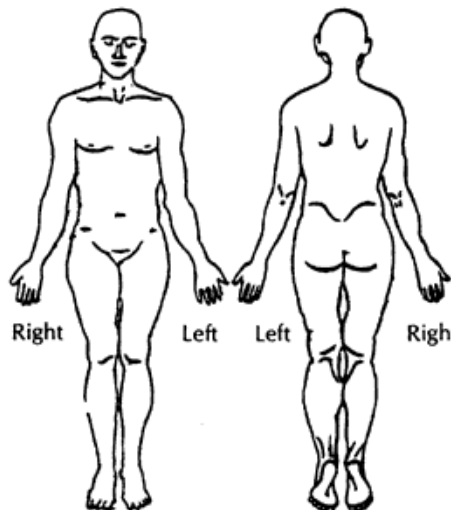
Where did your injury occur?

Work Auto Home NA-Gradual onset Other:

Which best describes how your injury occurred?

Shade areas of pain or discomfort on the figure below

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



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
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	Rheumatoid arthritis					
Asthma	Gout	Liver disease	Shortness of breath					
Back/Neck pain	Heart disease	Migraines	Skin condition					
Blood clots	Hepatitis	Multiple Sclerosis	Stroke /TIA					
Cancer	Hernia	Osteoarthritis	Swelling in feet/legs					
Chest pain	High blood pressure	Osteoporosis	Thyroid issues					
Depression	HIV+/AIDs	Pacemaker	Tuberculosis					
Diabetes	Imbalance	Parkinson's						
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: _____