

Integrity Rehab
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PHYSICAL THERAPY - GENERAL HEALTH QUESTIONNAIRE

Name: _____ Date: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Cell: _____
 E-mail: _____
 Age: ____ Date of Birth: _____
 Physician's Address: _____
 Phone: _____ Fax: _____

1. What problem has brought you to physical therapy?

2. MEDICAL HISTORY: (Check all conditions that apply to you)

	Check		Check		Check	FOR WOMEN ONLY	Check
Heart Disease		PAIN		MEDICAL CONDITIONS		Bowel/Bladder	
High Blood Pressure		No Pain Anywhere		Diabetes		Constipation	
Stroke		Feet		Fainting Spells		Diarrhea	
Pacemaker		Knees		Shortness of Breath		Hemorrhoids	
Heart Surgery		Hips		Dizziness		Urinary Leakage	
Discomfort in Chest		Shoulders		Kidney Disease		Irritable Bowel Syndrome	
Angina		Abdomen		Thyroid Problems		Surgery- Bladder	
High cholesterol		Back/Neck Pain		Difficulty Breathing		OB/GYN HISTORY	
High Triglycerides		Other		Labored Breathing		Hysterectomy -Vaginal	
Ankle Swelling		FAMILY HISTORY		Lung Problems		Hysterectomy- Abdominal	
BONES & JOINTS		Heart Attack		Cancer		Using Vaginal Cream	
Osteoporosis		Heart Disease		Depression/Anxiety		Ovaries Removed	
Scoliosis		High Blood Pressure		Visual Impairment		C-Section	
Fibromyalgia		Diabetes		Hearing Impairment		Laposcopic Surgery	
Arthritis		Other		Cigarette smoker		Scar Pain/Stuck Scar	
Dropped Arches/Feet				History of smoking		Pregnant	
Joint Replacements		SURGICAL HISTORY		Not smoking now		"Falling Out" Feeling	
		Back or Neck				Hormone Replacement	
other		Abdominal		Other		Pelvic Pain	
		Knee				Menstrual Pain	
		Other Joints				PMS	

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3. MEDICATIONS YOU ARE NOW TAKING:

4. SOCIAL HISTORY:

Marital Status: _____ Occupation: _____

Educational Level: (circle latest completed) High School College Graduate School

Hobbies: _____ # of family members living with you _____

What type of exercise are you doing now?

5. Check all the words that apply to how you feel these days:

Happy Calm Unmotivated Stressed Sad Overwhelmed Tired Afraid Lonely

Energetic Lethargic Content Optimistic Overworked Weak Flabby Strong

Un rested Other: _____

6. I prefer to learn by:

Listening (discussion, lecture, audio cassettes)

Seeing (reading, videos, displays, slides)

Doing (demonstration, practicing skill)

Don't know

7. Is English your primary language? (circle that which applies) Yes No

8. What areas of your body are of concern to you? (circle that which applies)

Arms Legs Back Neck Belly Bottom

9. WHAT ARE YOUR GOALS FOR PHYSICAL THERAPY? (circle that which applies)

Lessen pain Increase muscle strength/ tone Improve bladder control Other: _____

10. Any other comments?

Your Signature

Date

Your Name (Please Print)