AKTIVE MOTION PHYSICAL THERAPY

Patient Health History Questionnaire

Your therapist will discuss your responses with you during the evaluation.
Thank you for completing this information.

Name:_____ _____
(First) (Last)

SOCIAL HISTORY

Primary Language:_____

Occupation:_____

Work Status (Please Check One):

_____ Full Time _____ Part Time _____ Self-Employed _____ Not Employed

_____ Disabled _____ Retired _____ Student

Social Activities (interests/hobbies/exercise):_____

_____

Support System (who at home can help you if needed):_____

Primary Care Physician (if applicable):_____

Next scheduled Dr Appointment (Date):_____

CURRENT MEDICATIONS

Please provide us with a current list of your medications and/or herbal supplements or list them below

_____ _____

_____ _____

_____ _____

Name:_____ _____

(First) (Last)

CURRENT & PAST MEDICAL HISTORY

Do you have any allergies (adhesives, latex, cortisone, medications)? _____YES _____NO

If yes, please list with any reaction/treatments:

_____ Reaction/Treat_____

_____ Reaction/Treat_____

_____ Reaction/Treat_____

Place a "CHECK MARK" next to the condition/s that apply to you.

	Diabetes		Neurological Disorder		Anxiety
	Heart Disease		Stroke		Depression
	Pacemaker		Parkinson's		Panic Attacks
	High Blood Pressure		Epilepsy		HIV/AIDS
	Shortness of Breath		Hearing Difficulties		Hepatitis
	Lung Problems		Visual Difficulties		MRSA
	Unexplained Weight Change		Stomach or Bowel Disorders		Staph

I _____ have or I _____had CANCER (please check have or had): _____YES _____NO

Location/Body Part with Cancer:_____

I am still currently being treated for cancer: _____YES _____NO

Please describe any other problems not listed above:_____

Please list any past surgical procedures:

_____

_____

Name:_____ _____
(First) (Last)

KEY QUESTIONS ABOUT YOUR CONDITION

What is your **MAIN** problem?

_____

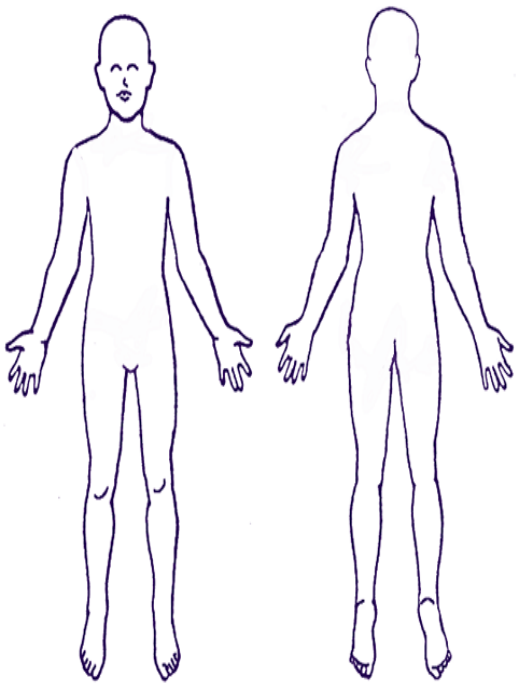
Check the box that describes your pain level **AT REST**
(Zero = no pain & 10 = severe pain)

0	1	2	3	4	5	6	7	8	9	10

Check the box that describes your pain level **WITH ACTIVITY**
(Zero = no pain & 10 = severe pain)

0	1	2	3	4	5	6	7	8	9	10

Place check marks on the body where you have **pain or numbness.**



Please indicate your present level of difficulty for each area listed below by checking the appropriate box for each activity.

	No Problems	Mild Difficulties	Moderate Difficulties	Severe Difficulties	Unable To Perform
Exercise					
Sleeping					
Sitting					
Standing (Getting up from sitting)					
Personal Care (Dressing/Bathing)					
Walking					
Lifting					
Social Life (Recreational & Social Activities)					
Traveling					