NEW ENGLAND BAPTIST HOSPITAL

Patient Name: _____

M. R. #: _____

D. O. B.: _____

Occupational Medicine – Physical Therapy
HEALTH QUESTIONNAIRE

Date: _____

What is the problem that brings you to physical therapy today? _____

_____

What are your goals for physical therapy? _____

Date of onset / injury: _____

Referring physician: _____ Date of next physician appointment: ____ / ____ / _____

Have you seen anyone else for your **current condition**? *(Please check all that apply)*

[ ] Physical Therapist [ ] Occupational Therapist / Hand Therapist [ ] Chiropractor

[ ] Pain Management [ ] Massage Therapist [ ] Acupuncturist

[ ] Other _____

Have you had physical therapy for this condition in the past? [ ] Yes [ ] No

Please check all diagnostic tests that you have had for your **current condition** only.

[ ] X-ray [ ] MRI [ ] CT Scan [ ] EMG [ ] Myelogram [ ] EEG [ ] Bone Scan

[ ] Other _____

How do you learn best? [ ] observing [ ] reading [ ] listening [ ] doing

[ ] Other _____

What is your occupation? _____

Work status: [ ] working [ ] light duty [ ] not working [ ] retired

Smoking history: [ ] never [ ] quit, when _____ [ ] smoking, _____ pack(s) / day

Alcohol intake: [ ] never [ ] socially [ ] moderately [ ] daily

Exercise: [ ] no [ ] yes, please explain what exercise you are doing and how frequently: _____

_____

Height: _____ feet _____ inches Weight: _____ pounds Hand dominance: [ ] left [ ] right

CL0500

Current Medications: Please include all over the counter medications, herbal supplements and vitamins / minerals.

Drug Name	Dosage and Frequency	Purpose

Please complete other side >

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HEALTH QUESTIONNAIRE

Medical History

	Yes	No	Comments		Yes	No	Comments
Chest Pain				Hypo / hyperthyroid			
Heart Attack				Anemia			
High Blood Pressure				Bleeding Disorder			
Stroke				Hepatitis			
Elevated Cholesterol				Difficulty with Vision			
Shortness of Breath				Difficulty with Hearing			
Bronchitis				Dizziness			
Emphysema				Headache			
COPD				Fainting			
Tuberculosis				Numbness			
Asthma				Muscle Weakness			
Diabetes				Paralysis			
Cancer				Seizures			
Osteoporosis				Nausea / vomiting			
Rheumatoid Arthritis				Bowel or Bladder Changes			
Osteoarthritis				Depression / Anxiety			
Weight gain or loss > 10 lbs in last month				History of Blood Clot or DVT			
Abdominal / Pelvic Pain				Other			

Are you pregnant or is there any possibility that you may be pregnant? [ ] Yes [ ] No

Allergies / Adverse Reactions: Latex [ ] Yes [ ] No

Other: _____

_____

Surgical History

Date	Facility	Procedure / Purpose

CL0500

In case of an emergency, contact: _____

Relationship: _____ Phone Number: _____

This medical history has been completed and is true to the best of my knowledge. I will inform my physical therapist of any changes that may occur during this episode of care.

Name of person completing form: _____ Date: _____

Patient Signature: _____ Date: _____

Physical Therapist Signature: _____ Date: _____