HARTZ PHYSICAL THERAPY

Evaluation: Health Questionnaire

Patient Name: _____ Date of Birth: _____

Height / Weight: _____ Onset Date of Symptoms: _____

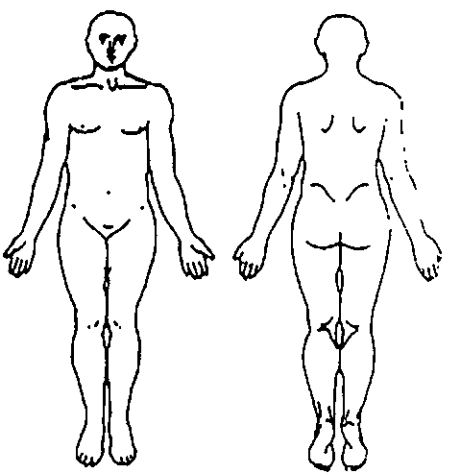
Next Scheduled Visit with Physician: _____

Occupation: _____

Has this injury / condition affected your work status? _____

What are your Recreational Activities / Hobbies: _____

Please mark the following diagrams the location of your pain (and/or numbness, burning, tingling):



Please indicate the intensity of your pain: No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

ALLERGIES: List any medication(s) you are allergic to: _____

Are you latex sensitive? Yes No List any other allergies we should know about _____

Have you declared the Advanced Clinical Directive of Do Not Resuscitate? Yes No

Date of last physical examination _____

Have you EVER been diagnosed as having any of the following conditions?

YES NO Cancer. If YES, what kind: _____
YES NO Heart Problems. If YES, what kind: _____
YES NO High blood pressure
YES NO Circulation problems
YES NO Asthma
YES NO Stomach ulcers
YES NO Chemical dependency (i.e. alcoholism)
YES NO Thyroid problems
YES NO Diabetes
YES NO Multiple sclerosis
YES NO Rheumatoid arthritis/Inflammatory disorders
YES NO Other arthritic conditions

YES NO Depression
YES NO Hepatitis
YES NO HIV/AID'S
YES NO Tuberculosis
YES NO Stroke
YES NO Kidney disease.
If YES, what kind: _____
YES NO Blood clots
YES NO Osteoporosis
YES NO Headaches
YES NO Migraine Headaches
YES NO Other _____

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

SURGERIES/HOSPITALIZATIONS INCLUDE DATE AND REASON

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

YES	NO	Diabetes	YES	NO	Cancer
YES	NO	Heart disease	YES	NO	Alcoholism (chemical dependency)
YES	NO	High blood pressure	YES	NO	Depression
YES	NO	Stroke	YES	NO	Kidney Disease
YES	NO	Inflammatory Arthritis (Rheumatoid, Ankylosing)			

Which of the following medications have you taken in the last week?

	Physician Prescribed
❑ Aspirin	YES/NO
❑ Tylenol	YES/NO
❑ Anti-inflammatories (Advil/Motrin/Ibuprofen, etc.)	YES/NO
❑ Stomach ulcer medications	YES/NO
❑ Vitamins/mineral supplements	YES/NO
❑ Herbals/Remedies	YES/NO

Others NOT prescribed by a physician _____

Please list any other physician-prescribed medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

How much caffeinated coffee or caffeine containing beverages do you drink per day? _____

Tobacco use: How many packs do you smoke per day _____ for how many years _____. If quit, when? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____

Please circle any of the following that are NEW, UNUSUAL or ATYPICAL for you:

YES	NO	weight loss/gain	YES	NO	joint/muscle swelling
YES	NO	nausea/vomiting	YES	NO	easy bruising
YES	NO	dizziness/lightheadedness	YES	NO	excessive bleeding
YES	NO	fatigue	YES	NO	difficulty breathing
YES	NO	weakness	YES	NO	regular cough
YES	NO	fever/chills/sweats	YES	NO	arm/leg swelling
YES	NO	numbness or tingling	YES	NO	heart racing in your chest/irregular heartrate
YES	NO	tremors	YES	NO	difficulty swallowing
YES	NO	seizures	YES	NO	heartburn/indigestion
YES	NO	double vision	YES	NO	constipation/diarrhea
YES	NO	loss of vision	YES	NO	blood in stool
YES	NO	eye redness	YES	NO	post menopause
YES	NO	skin rash	YES	NO	problems urinating (difficulty starting, painful, etc.)
YES	NO	problems sleeping	YES	NO	urinary incontinence
YES	NO	sexual difficulties	YES	NO	blood in the urine
YES	NO	night sweats	YES	NO	pregnant or think you might be pregnant
YES	NO	hearing problems	YES	NO	stress at home or work

_____ _____

Therapist Signature Date Patient Signature Date