PATIENT QUESTIONNAIRES ON ADMISSION

1. Name (last, first): _ _______________________ _ _ _ _ _

Sex: □Male □Female

2. Are you: □Right handed □Left handed

3. Race: □Asian □Native Hawaiian/Pacific Islander

□White □Black

4. Ethnicity: □ Hispanic or Latino □Not Hispanic or Latino:

5. Language: □English Interpreter needed □what language you speak most often:

6. Cultural/Religious: _

(Any customs or religious beliefs or wishes that might affect care)

7. Education (Highest grade completed):

□Some College/technical school

□College graduate

□Graduate school/advanced degree

8. Employment

□Working full time outside of home

□Working full time from home

□Working part time outside of home

□Working part time from home

□Home maker □Student

□Retired □Unemployed

9. Occupation: _

10. Have you completed an advanced directive: □Yes □No?

11. Who referred you to the Physical Therapy? _

12. Where do you live?

□Private Home □Private apartment

□Rented Room □Board and care/assisted living/group home

□Homeless (with or without shelter)

□Long term care facility (Nursing home)

□Hospice □Other

13. Whom do you live?

□Alone □Spouse only □Spouse and others

□Child □Other relatives' □Group setting

□Personal care attendant □Other

14. Does your home have?

□Stairs, no railing □Stairs, railing □Ramps

□Elevator □Uneven terrain □other

Patient Name: ______________________________

15. Do you use:

□Cane □Walker or Rollator □Manual Wheelchair
□Motorized wheelchair □Others:

16. General Health

□Excellent □Good □Fair □Poor

17. Have you had any major life changes during past year (eg: new baby, job change, death of a family member): □Yes □No

18. Social/Health habits:

Smoking: □Yes □No
Alcohol: □Yes □No
Exercise: □Yes □No

19. Family History:

□Heart Disease □Hypertension
□Stroke □Diabetes
□Cancer □Psychological
□Arthritis □Osteoporosis

20. Medical / Surgical history:

□Arthritis □Broken bones/fractures
□Blood disorders □Circulation/Vascular problems
□High blood pressure □Lung problems
□Diabetes □Head injury
□Muscular dystrophy □Parkinson's disease
□Allergies □Developmental or growth problems
□Infectious disease □Kidney problems
□Ulcers/stomach problems □Skin Diseases
□Depression □Thyroid Problems
□Osteoporosis □Heart problems
□Stroke □Multiple Sclerosis
□Seizures/epilepsy □Other:
□Repeated infections

21. Within the past year, have you had any of the following symptoms? (Check all that apply)

□Chest pain □Heart palpitations
□Hoarseness □Short of breath

Patient Name: _____

□Coordination problems

□Loss of balance	□Difficulty walking
□Pain at night	□Difficulty sleeping
□Nausea/vomiting	□Bowel problems
□Urinary problems	□Fever/Chills/Sweats
□Hearing problems	□Vision problems
□Cough	□other
□Dizziness or blackouts	□Weakness in arm or legs
□Joint pain or swelling	□Loss of appetite
□Weight loss/gain	□Headaches

22. Have you ever had surgery □Yes □No

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23. Men only:

Have you been diagnosed with prostate disease? □Yes □No

24. Women only:

Have you been diagnosed with?

Pelvic inflammatory disease	□Yes	□No
Endometriosis:	□Yes	□No
Trouble with your period	□Yes	□No
Complicated pregnancies	□Yes	□No
Pregnant, or think you might pregnant	□Yes	□No
Other gynecological or obstetrical difficulties	□ Yes	□No

25. Current Conditions / Chief Complaints: _

When did the problems begin? _

What happened? _

_ _

26. Have you ever had the problems before? □Yes □No

27. Current conditions:_ _

What activities are you not able to do now that you could do before the problems?

_ _

What are your goals for Physical Therapy? _

28. Are you seeing anyone else for problems(s) (Check all that apply)

□Acupuncturist	□Cardiologist
□Chiropractor	□Dentist
□Family practitioner	□Internist

Patient Name: _____

□Massage therapist □Neurologist
□OBGYN □Occupational Therapist
□Orthopedist □Osteopath
□Pediatrician □Podiatrist
□Primary care physician □Rheumatologist

29. Functional status/activity level

Difficulty with locomotion/movement:

□Bed mobility:

□Transfers (such as moving from bed to chair, from bed to commode)

□Gait: □On level □On ramps
□On stairs □On uneven terrain

□Difficulty with self care (Such as bathing, dressing, eating, toileting):

□Difficulty with home management (Such as house hold chores, shopping, driving)

□Difficulty with community and work activities/integration

□Work/school □Recreation or play activity

30. Medications:

Do you take any prescription medications? Yes No

If yes please list: _
_ _
_ _

31. Have you taken any medications previously for the condition for which you are seeing the physical therapist? □Yes □No

Please list: _
_ _

32. Other clinical test:

□Angiogram □Mammogram
□Arthroscopy □MRI
□Biopsy □Myelogram
□Blood tests: □NCV
□Bone scans □Pap smear
□Bronchoscope □Pulmonary function test
□CT scan □Spinal tap
□Doppler ultrasound □Stool tests
□Echocardiogram □Stress test
□EEG □Urine tests
□EKG □X-rays
□EMG □Others:

Patient Name: _____