Hopkins Health & Wellness Center Lakes Area

Health History Questionnaire

Date: _____

Patient Name: _____

What problem brings you in today? _____
_____

When did this problem begin? _____

Where did it happen? □ home □ work □ sports/rec
□ motor vehicle accident □ unknown □ other

Do you have pain? □ yes □ no
If yes, the pain: □ constant □ comes and goes

Rate the pain based on 0-10 scale:

0 = no pain	At best _____
1-2 = mild	At worst _____
3-4 = discomfort	Current _____
5-6 = distressing	
7-8 = horrible	
9-10 = excruciating	

Describe nature of symptoms/concerns:

□ dull	□ throbbing	□ sharp
□ numbness	□ tingling	□ aching
□ burning	□ dizziness	□ bowel/bladder changes
□ spasms	□ weakness	□ vision changes
□ nausea	□ headaches	□ other: _____

What makes symptoms better? _____
What makes symptoms worse? _____

Indicate previous treatment for this problem: □ physical therapy
□ chiropractic □ massage therapy □ occupational therapy
□ medications/injections □ surgery □ none □ other _____

At this time, are symptoms: □ better □ worse □ same

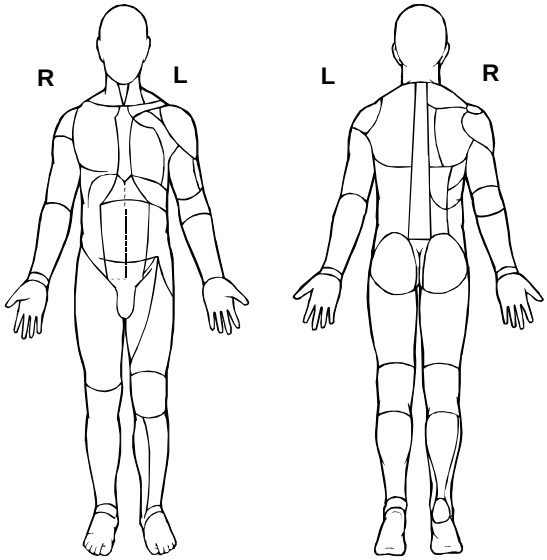
Indicate any health conditions that you have: □ cancer □ stroke
□ diabetes □ high blood pressure □ tuberculosis □ anemia
□ arthritis □ asthma □ seizures □ heart problems □ hepatitis
□ osteoporosis □ mental illness □ depression/anxiety □ smoker
□ menopause □ multiple sclerosis □ overweight □ chemical dep
□ thyroid disease □ kidney disease □ unexplained weight loss
□ dizziness/vertigo □ imbalance problems □ high cholesterol
□ currently pregnant □ other _____

What is your status? □ employed □ student □ homemaker
□ unemployed □ retired □ disabled
If employed, what is your occupation? _____

You are: □ working without restrictions □ working with restrictions
□ working in alternate job □ currently not working

Indicate primary job tasks: □ prolonged sitting □ driving
□ prolonged standing □ climbing □ operating machines
□ lifting _____ lbs □ repetitive (computer, writing, etc)

Identify location of pain/symptoms:



Do you have sleep disturbance? □ yes □ no
Awaken _____x/night □ discomfort □ difficulty falling asleep
Position: □ back □ Side (Left / Right) □ stomach

What is your standing tolerance? ___ minutes / ___ distance
Sitting tolerance? ___ minutes / ___ distance
Walking tolerance? ___ minutes / ___ distance
Lifting tolerance? ___ minutes / ___ distance

Indicate any special tests for this problem: □ X-ray □ MRI
□ EMG □ CT scan □ other_____
What were the results? _____

List any surgeries/injuries that you have had (even not related to current problem): _____
_____

Indicate any medications that you are taking: □ anti-inflammatory
□ pain □ muscle relaxants □ supplements □ blood pressure
□ cholesterol □ cardiac □ thyroid □ heparin/coumadin □ steroid
□ hormone □ antidepress/anxiety □ other _____

List any leisure/recreational/sport activities that you participate in:
_____
_____

Regular exercise program: □ yes □ no
Describe: _____

List anything you would like to accomplish with therapy that is limited due to your problem at this time: (What do you want to get back to doing?)
_____
_____
_____

Health History Questionnaire – continued

What are your functional goals?

- ***(ie: What would you like to get back to doing with the help of therapy? (walking, running, dancing, etc.)***

1. _____

2. _____

3. _____

4. _____