Patient Information Questionnaire

CONFIDENTIAL INFORMATION

The information contained in this questionnaire will be used to help determine the most appropriate Physical Therapy treatment required in helping to restoring your highest functional ability. All information is considered confidential and will be released only to your physician unless prior written authorization is given.

Patient Name: ____

1. What problems brought you to Advanced Health Systems?

   ____

2. Have you ever been treated for this condition before? Yes No

   If yes, when and by whom: ____

3. What were you able to do before without pain, discomfort or restriction that you are unable to do now? (check all that apply)

   ____ bend ____ grip ____ lie down ____ sleep ____ reach
   ____ walk ____ drive ____ lift ____ work ____ stand up
   ____ work at home ____ sit down ____ other: ______________
   ____ other: ____________ ____ other: ______________
   ____ other: ____________ ____ other: ______________

4. What do you hope to gain as a result of Physical Therapy treatment? (check all that apply)

   __ Improved movement __ Improved posture __ Decreased muscle spasms

   __ Improved strength __ Improved endurance __ Improved home work ability

   __ Decreased pain __ Increased work ability __ Improved walking and balance

   Other (list):____

6. What medications are you presently taking, if any? _________________________

   ____

7. Are you now or do you think you may be pregnant? Yes No

   If yes, what trimester: 1st 2nd 3rd

8. Do you now have or have you ever been treated for cancer or any malignancy? Yes No

   If yes, when:____

9. What allergies do you have? ______________________________________

   ____

10. Do you have any new complaints or problems since your physician referred you for Physical Therapy services? Yes No

   If yes please explain: ____

   ____

I certify by my signature that the foregoing information is accurate and truthful to the best of my knowledge.

Date__________________ Patient's Signature ___________________________________

Date__________________ Physical Therapist Signature ___________________________