



Patient Name _____

Physician _____

Date _____

Physical Therapy Patient Questionnaire

1. With whom do you live?

- Alone Sitter Spouse Family
- Patient is primary care giver Other _____

2. Employment/Work

- Working full-time Working part-time Retired
- Unemployed Student Work from home

Occupation _____

3. Dwelling:

- House
- Assisted Living
- Apartment

Equipment used:

- Cane
- Walker
- Wheelchair

4. Do you have:

- Stairs to climb Glasses, hearing aids
- Railing Assisted devices for bathing/dressing
- Uneven terrain Other _____

5. Functional Status/Activity Level (Check all that apply)

- Difficulty with: Bed mobility Transfers (moving from bed to chair/bathroom)
- Difficulty walking
- Problem areas: level ground on stairs ramps uneven terrain
- Difficulty with self care (bathing, dressing, eating, toileting)
- Difficulty with home management (household chores, shopping, gardening, driving, care of dependent)
- Difficulty with community and work activities/integration
- Work/school Recreation or play activities

6. If student, school you are currently attending: _____

Current Condition / Chief Complaint

7. Describe the problem for which you seek therapy _____

When did the problem begin (date) Month _____ Year _____

What happened: _____

Have you ever had this problem before? Yes No

If yes, what did you do for the problem? _____

Is this the result of a car accident? If yes, describe the accident _____

8. When is it the worst? Morning Evening Constant Standing

Sitting Walking Driving

Other _____

How are you taking care of the problem now? _____

What makes the problem better? _____

What makes the problem worse? _____

9. What procedures have you had for this problem? (Check all that apply)

- Xray MRI CT Injections/blocks Surgery
- Other _____



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Medical History (Please check all that apply)

- Coronary heart disease Congenital heart disease Heart Murmurs Angina (chest pain) _____
- Irregular heart beat Pacemaker Valve problems Heart attack
- High blood pressure Stroke Diabetes Epilepsy/Seizures
- Cancer – Type: _____ Stomach ulcers
- Lung Disease (COPD, Asthma, Emphysema.....) – Type _____
- Arthritis -- Type: Rheumatoid Osteoarthritis
- Where: _____
- Osteoporosis Fracture related to Osteoporosis (wrist, spine, hip,etc.)
- Surgery in the last 12 months - Body part: _____ When _____
- Any chronic illness or condition – What type? _____
- Allergies – Please list _____
- Hernia (or any condition which can be aggravated with lifting)
- Current smoker Former smoker
- Pregnant / Possibly pregnant
- Memory Loss / Alzheimer’s / Dementia Circulation/Vascular Problems
- Problems with swelling Location: _____
- Previous Broken Bones Location _____
- Balance Disorder Vertigo Depression
- Other – Please List _____

Please list any medications that you are taking for the above conditions or your current injury:

14. We occasionally have Physical Therapy Interns who perform clinical rotations at our facility. These individuals will be working with the therapist that is treating you. Do you agree to allow an intern participate in your sessions? Yes No

15. In the event that we recommend continued exercise in the Fitness, Wellness Center or Spa, I hereby authorize One Nineteen Physical Therapy to release copies of my Medical Record to these services on a need to know basis. Yes No

Thank you for choosing One Nineteen Health and Wellness for your physical therapy needs!

Patient’s Signature _____ **Date** _____

Therapist Signature _____ **Date** _____