PHYSICAL THERAPY GENERAL HEALTH QUESTIONNAIRE

Name:______________________________ ______________**Why are you here?**____

Check all the Conditions that apply to you:

HEART/CIRCULATION	√	**MEDICAL PROBLEMS**	√	**FOR WOMEN ONLY**	
Heart Disease		Diabetes		***CHILDBEARING HISTORY***	
High Blood Pressure		Fainting Spells		Are you Pregnant? Yes No If yes, what is your due date:____________________________	
Pacemaker		Cancer			
Heart Surgery		Dizziness			
Pain/tightness in chest		Thyroid Problems		If yes, are you planning to breastfeed?	Yes No Don't Know
Stroke		Falls the last 6 mos.		# of Pregnancies – If this is your first pregnancy, skip the next section	0 1 2 3 4 5 +
BONES & JOINTS		# trips/slips/near falls			
Osteoporosis		Depression		***COMPLETE THE SECTION BELOW ONLY IF YOU HAVE HAD MORE THAN ONE PREGNANCY.***	
Scoliosis		**LUNG/BREATHING**			
Fibromyalgia		Difficulty breathing		# of Children (circle one number)	0 1 2 3 4 5 +
Plantar fascitis		Shortness of Breath			
Dropped arches/flat feet		Smoke cigarettes now		# of Miscarriages (circle one number)	0 1 2 3 4 5 +
Numbness in feet/legs		History of smoking		# of Vaginal deliveries (circle)	0 1 2 3 4 5 +
Tailbone fracture		**SURGICAL HISTORY**			
Joint Replacements		Back or neck		# of C-Sections (circle one number)	0 1 2 3 4 5 +
Swelling in Ankles/feet		Tubal Ligation			
AREAS OF PAIN		Laproscopy		Birth weight of largest baby	
Back ("sciatica like pain")		Abdominal Hysterectomy			
Neck		Vaginal Hysterectomy		# of episiotomies (circle one number)	0 1 2 3 4 5 +
Ribs		Gall Bladder			
Shoulders		Bladder surgery		# of forceps deliveries	0 1 2 3 4 5 +
Abdomen/belly		**FAMILY HISTORY**			
Tailbone		Heart Disease		***IF YOU ARE NOT PREGNANT, PLEASE COMPLETE THE SECTION BELOW***	
Wrist ("carpal tunnel")		High Blood Pressure			
Swelling in the hands		Diabetes		Are you trying to get pregnant	Yes No
Feet		Cancer		Do you have symptoms of leaking urine	Yes No
Knees		Stroke		Do you have constipation	Yes No
Hips		Osteoporosis		Do have pain with sexual intercourse	Yes No
Other					

LIST ALL THE MEDICATIONS YOU ARE TAKING, INCLUDING HERBAL AND OVER THE COUNTER MEDICATIONS:

Name of Medication	**For what?**	**Name of Medication**	**For What?**

SOCIAL, OCCUPATIONAL AND RECREATIONAL ACTIVITIES

Marital Status: __Single __Married ___Separated __Divorced __ # of people that live with you:________________

Do you feel safe at home? ___Yes ____ No Comment:____

Occupation:_____________________________ Physically this means I ___sit ___stand __walk most of the day

Educational Level __________ **Hobbies**: __________________________ ___________________________________

EXERCISE HISTORY:
___No exercise ___Walk ______________________________ ____Go to gym __________________________________

Other____

CHECK THE WORDS THAT APPLY TO HOW YOU FEEL THESE DAYS &/OR CHOOSE YOUR OWN WORDS:

DESCRIPTOR	√		√		√		√		√		√		√
Happy →		Calm →		Unmotivated		Stressed		Lonely		Content		Depressed	
Overwhelmed →		Sad →		Tired		Afraid		Energetic		Optimistic		"Postpartum blues"	
Flabby →		Strong →		Un-rested		Lethargic		Weak		Overworked		Not bonding with baby(ies)	
Anxious →		Unsafe →		Abused		Neglected							

HOW DO YOU LEARN?: ___Listening (lecture, discussion) ___Seeing (read, video, DVD) __Doing (practicing skill)

Is English your primary language? ___Yes ____No. If no, would you need a translator when you are in therapy? _________

NUTRITION:
How much do you weigh? ________pounds

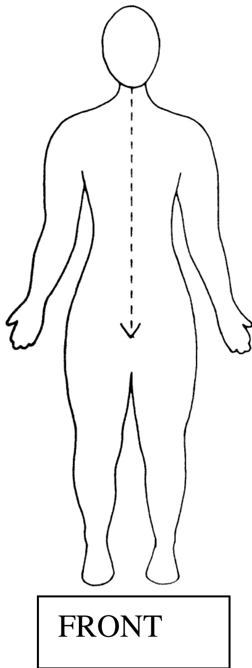
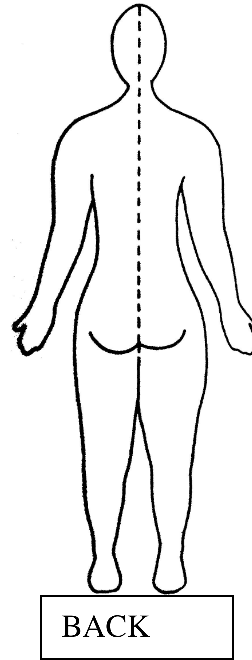
		If you answered YES, please explain
Would you like to ___lose or ____gain weight?	Yes No	How many pounds?_________________
Have you gained more than 10 pounds in the last year?	Yes No	How many pounds?_________________
Have you lost more than 10 pounds in the last year?	Yes No	How many pounds?__________________
Are you on any special diet?	Yes No	__Low Carb ___Atkins ___South Beach __Weight Watchers __Diabetic __Other______
Would you say your diet is "unhealthy"?	Yes No	__too many fast foods __Not enough vegetables __High Fat __High Carb __Other__________

FLUID INTAKE: What do you drink every day?
____8 ounce glasses of water ___cans of diet soda ___cans of regular soda ___8 ounce cups of regular coffee
____8 ounce cups of decaffeinated coffee ____8-ounce cups/glasses of tea ____16-ounce cans of beer
____glasses of wine ___glasses of liquor ___ 8-ounce glasses of milk ____8-ounce glasses of juice____________
____Other____

Anything else you would like us to know about you?____

TELL US ABOUT YOUR PAIN

Please mark with an "X" where your pain begins. Shade any other areas of pain

FRONT BACK

CHECK ALL THE WORDS THAT DESCRIBE YOUR PAIN:
___Numb ___Stabbing ___Burning ___Irritating ___Aching ____Throbbing ___Tender ___Unbearable ___Shooting
___Sharp __Constant __Other____

WHAT MAKES YOUR PAIN WORSE?
___Sitting ___standing ___Walking ___Getting out of bed ___exercise ___sexual intercourse ___menses
___Getting up from sitting position ___Working at home all day ___Being at work all day ___Exercise
___Other____

WHAT MAKES YOUR PAIN BETTER?
____Heating pad ___Ice pack ___Resting in bed ___Resting in Chair ___walking ___Medication ___Exercise
____Other ____

CHECK ALL THE STATEMENTS THAT ARE TRUE:
____ I have numbness or tingling in my legs ____I have numbness or tingling in my arms or hands
____ There is a change in the way my bladder or bowels work since this problem started
____ I feel dizzy ___I have blurred vision.

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? ____None or:

TREATMENTS	HAS IT HELPED?	TREATMENTS	HAS IT HELPED?
Medication(s)	Yes No A little	Physical Therapy	Yes No A little
Chiropractic	Yes No A little	Other	Yes No A little
Surgery	Yes No A little	Other	Yes No A little