

## 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		<b><u>CHILDBEARING HISTORY</u></b>
<input checked="" type="checkbox"/> High Blood Pressure		Fainting Spells		Are you Pregnant? Yes No
Pacemaker		Cancer		If yes, what is your due date: _____
Heart Surgery		<input checked="" type="checkbox"/> Dizziness		
Pain/tightness in chest		Thyroid Problems		If yes, are you planning to breastfeed? Yes No Don't Know
<input checked="" type="checkbox"/> Stroke		<input checked="" type="checkbox"/> Falls the last 6 mos.		# of Pregnancies – If this is your first pregnancy, skip the next section 0 1 2 3 4 5 +
<b>BONES &amp; JOINTS</b>		<input checked="" type="checkbox"/> # trips/slips/near falls		<b>COMPLETE THE SECTION BELOW ONLY IF YOU HAVE HAD MORE THAN ONE PREGNANCY.</b>
Osteoporosis		<input checked="" type="checkbox"/> Depression		
Scoliosis		<b>LUNG/BREATHING</b>		# of Children (circle one number) 0 1 2 3 4 5 +
Fibromyalgia		Difficulty breathing		# of Miscarriages (circle one number) 0 1 2 3 4 5 +
Plantar fasciitis		Shortness of Breath		# of Vaginal deliveries (circle) 0 1 2 3 4 5 +
Dropped arches/flat feet		Smoke cigarettes now		# of C-Sections (circle one number) 0 1 2 3 4 5 +
<input checked="" type="checkbox"/> Numbness in feet/legs		History of smoking		Birth weight of largest baby
Tailbone fracture		<b>SURGICAL HISTORY</b>		# of episiotomies (circle one number) 0 1 2 3 4 5 +
Joint Replacements		Back or neck		# of forceps deliveries 0 1 2 3 4 5 +
Swelling in Ankles/feet		Tubal Ligation		<b>IF YOU ARE NOT PREGNANT, PLEASE COMPLETE THE SECTION BELOW</b>
<b>AREAS OF PAIN</b>		Laproscopy		Are you trying to get pregnant Yes No
Back (“sciatica like pain”)		Abdominal Hysterectomy		Do you have symptoms of leaking urine Yes No
Neck		Vaginal Hysterectomy		Do you have constipation Yes No
Ribs		Gall Bladder		Do have pain with sexual intercourse Yes No
Shoulders		Bladder surgery		
Abdomen/belly		<b>FAMILY HISTORY</b>		
Tailbone		Heart Disease		
Wrist (“carpal tunnel”)		High Blood Pressure		
Swelling in the hands		Diabetes		
Feet		Cancer		
Knees		Stroke		
Hips		Osteoporosis		
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	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		
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 <input type="checkbox"/> lose or <input type="checkbox"/> 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	<input type="checkbox"/> Low Carb <input type="checkbox"/> Atkins <input type="checkbox"/> South Beach <input type="checkbox"/> Weight Watchers <input type="checkbox"/> Diabetic <input type="checkbox"/> Other _____
Would you say your diet is “unhealthy”?	Yes No	<input type="checkbox"/> too many fast foods <input type="checkbox"/> Not enough vegetables <input type="checkbox"/> High Fat <input type="checkbox"/> High Carb <input type="checkbox"/> Other _____

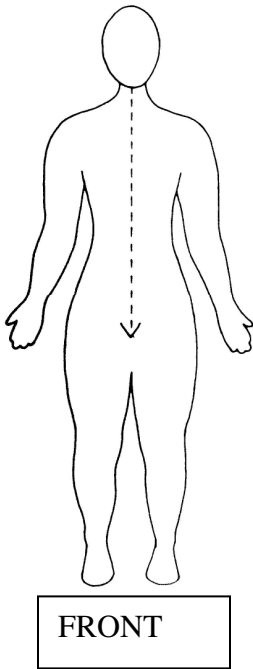
**FLUID INTAKE: What do you drink every day?**

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 \_\_\_\_\_

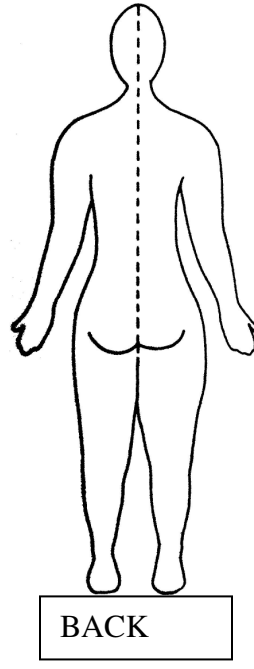
Anything else you would like us to know about you? \_\_\_\_\_

**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