TERRIO
Therapy-Fitness

HISTORY QUESTIONNAIRE

Name: _____Date of Birth: _____/_____/_____ Age:_____

Is this injury related to an Auto Accident? ❑ Yes ❑ No

Did this injury happen while at Work? ❑ Yes ❑ No

Do you have a current Workers Compensation Claim Open? ❑ Yes ❑ No

I am: ❑ Male ❑ Female

I am living: ❑ Alone ❑ Alone but with assistance for my needs
❑ With an adult person(s) ❑ With children in home, ages_____

I am currently: ❑ Employed; my job is _____
❑ I am on a sick leave ❑ I am on disability ❑ Applying for disability
❑ I am unemployed ❑ I am retired ❑ I work inside the home

My physical activities include:
❑ Reading, watching TV
❑ Walking, gardening, housework, occasional physical exercise
❑ Regular physical exercise at least twice per week

I began having pain/symptoms on or about: _____/ _____/_____

I have had this condition: ❑ Never until now ❑ Once ❑ Many times before

My pain/symptoms were caused by (check all that apply):
❑ Accident or Injury Explain: _____
❑ Surgery Explain: _____
Date of surgery:_____/_____/_____
❑ Suddenly without any reason
❑ Gradually worsening over time
❑ Due to a change or increase in activity
❑ Don't know

My symptoms are currently: ❑ Getting Better ❑ Getting Worse ❑ Staying about the same

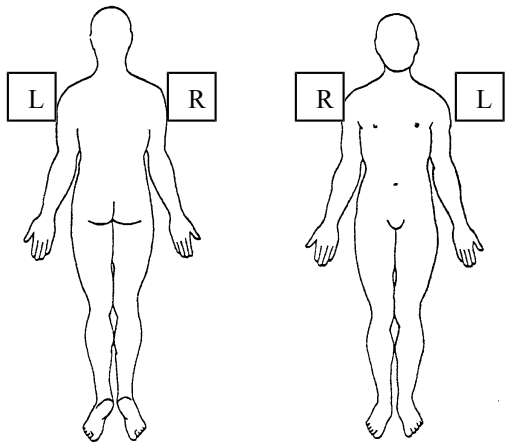
What makes your symptoms worse (check all that apply):
❑ Lying down ❑ Standing ❑ Walking ❑ Sitting ❑ Stress
❑ Other:_____

What makes your symptoms better:_____
_____

Body Chart:

On the chart to the right, please mark the areas where you feel symptoms, by using the following symbols:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



I would rate my pain *CURRENTLY* as:

0 1 2 3 4 5 6 7 8 9 10
(None) (Annoying) (Uncomfortable) (Horrible) (Excruciating)

The ***LEAST*** pain I have had ***IN THE LAST WEEK*** is:

0 1 2 3 4 5 6 7 8 9 10
(None) (Annoying) (Uncomfortable) (Horrible) (Excruciating)

The ***WORST*** pain I have had ***IN THE LAST WEEK*** is:

0 1 2 3 4 5 6 7 8 9 10
(None) (Annoying) (Uncomfortable) (Horrible) (Excruciating)

I am currently taking the following medications (check all that apply):

❑ Pain pills ❑ Anti-inflammatory medication
❑ Muscle relaxants ❑ Antidepressants
❑ Blood thinners
❑ Please list medication(s) or attach a list:

_____

_____

Allergies:_____

I have had these tests done recently:

❑ None ❑ X-ray ❑ MRI ❑ CAT Scan
❑ Ultrasound ❑ Other:_____
Please describe any results:_____

I have had these treatments for any reason:

❑ Physical Therapy ❑ Occupational Therapy
❑ Chiropractic Care ❑ Other:_____
❑ None
Past Surgeries:_____

I have RECENTLY had the following symptoms (check all that apply):

❑ stiffness
❑ swelling
❑ radiating pain down arms
❑ radiating pain down legs
❑ lack of strength / awkwardness with my hands
❑ lack of strength / awkwardness with my legs
❑ difficulty maintaining balance while walking
❑ shortness of breath
❑ fever / chills / sweats
❑ dizziness / lightheadedness
❑ unexplained weight loss / gain
❑ heartburn / indigestion
❑ recurring headaches
❑ difficulty sleeping
❑ muscle weakness
❑ spasms
❑ difficulty swallowing
❑ fainting
❑ fatigue
❑ cough
❑ falls

❑ increased pain at night ❑ numbness / tingling ❑ nausea / vomiting
❑ bowel or bladder changes ❑ confusion ❑ changes in skin

I have (or have had) (check all that apply):

❑ cancer ❑ depression /anxiety ❑ thyroid problems
❑ arthritis ❑ rheumatoid arthritis ❑ osteoporosis
❑ anemia ❑ seizures ❑ blood clots
❑ heart disease / condition ❑ lung problems ❑ drug or alcohol abuse
❑ chest pain / angina ❑ plastic or metal implants ❑ stroke
❑ asthma ❑ liver problems ❑ pacemaker
❑ circulation problems ❑ ulcers ❑ fibromyalgia
❑ bladder / kidney problems ❑ GYN problems _____
❑ other _____
❑ high blood pressure (If yes, is this well controlled) ❑ yes ❑ no ❑ unsure
❑ diabetes (If yes, is this well controlled) ❑ yes ❑ no ❑ unsure
current smoker ❑ yes ❑ no ***past*** smoker ❑ yes ❑ no ***currently*** pregnant ❑ yes ❑ no

During the past month, have you often been bothered by little interest or pleasure in doing things that you enjoy? ❑ Yes ❑ No

During the past month have you often been feeling down, depressed or hopeless? ❑ Yes ❑ No

If yes, is this something with which you would like help? ❑ Yes, but not today ❑ Yes ❑ No

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ❑ Yes ❑ No

What activities are you having difficulty doing because of your pain or dysfunction? _____
_____

What is your personal goal for therapy?_____
_____

Is there any other information or concerns you would like to share with your therapist?_____
_____

Patient Name (Printed):_____ Date:_____

Patient/Guardian Signature:_____

To our patients: Although many of these questions may not seem relevant to your visit today, we ask that you communicate with us regarding symptoms or history you have, as this information can be of great assistance in determining whether therapy is indicated, and to what degree it may be of help. And even if your provider is aware of a symptom or illness, please let us know about it, and also if there has been any worsening of late. An important aspect of treating musculoskeletal injuries is screening for other conditions and factors that may play a role in your symptoms; this helps us to provide effective interventions, and to be advocates for your overall wellbeing and health.

For therapist use:

Self reported or functional index score: _____/_____

Oswestry Cervical Index DASH LEFS UEFI FABQ FAAM Other:_____

Therapist signature Date