Women's Center for Wellness and Rehabilitation

Evaluation for Orthopedic issues

DEMOGRAPHIC AND INSURANCE INFORMATION (PHYSICAL THERAPY DEPARTMENT)

PHYSICAL THERAPY GENERAL HEALTH QUESTIONNAIRE

Name:_____ _____**Why are you here?**_____

Check all the Conditions that apply to you:

HEART/CIRCULATION	**v**	**MEDICAL PROBLEMS**	**v**
Heart Disease		Diabetes	
High Blood Pressure		Fainting Spells	
Pacemaker		Cancer	
Heart Surgery		Dizziness	
Pain/tightness in chest		Thyroid Problems	
Stroke		Falls the last 6 mos.	
BONES & JOINTS		# trips/slips/near falls	
Osteoporosis		Depression	
Scoliosis		**LUNG/BREATHING**	
Fibromyalgia		Difficulty breathing	
Plantar fascitis		Shortness of Breath	
Dropped arches/flat feet		Smoke cigarettes now	
Numbness in feet/legs		History of smoking	
Tailbone fracture		**SURGICAL HISTORY**	
Joint Replacements		Back or neck	
Swelling in Ankles/feet		Tubal Ligation	
AREAS OF PAIN		Laproscopy	
Back ("sciatica like pain")		Abdominal Hysterectomy	
Neck		Vaginal Hysterectomy	
Ribs		Gall Bladder	
Shoulders		Bladder surgery	
Abdomen/belly		**FAMILY HISTORY**	
Tailbone		Heart Disease	
Wrist ("carpal tunnel")		High Blood Pressure	
Swelling in the hands		Diabetes	
Feet		Cancer	
Knees		Stroke	
Hips		Osteoporosis	
Other			

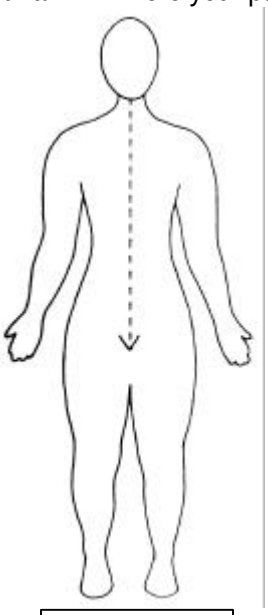
LIST ALL THE MEDICATIONS YOU ARE TAKING, INCLUDING HERBAL AND OVER THE COUNTER MEDICATIONS:

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

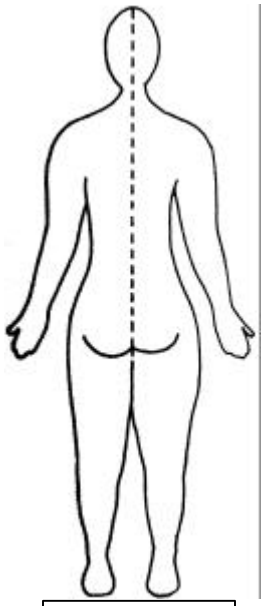
Patient Label Here

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

Patient Label Here