Brewer/Ellsworth Physical Therapy
Health Questionnaire

NAME: _____ DATE:_____

The purpose of this questionnaire is to assist us in providing you quality care by obtaining a better understanding of your total health status. This questionnaire is considered a part of your confidential medical record.

Chief problem of complaint_____

A. Medical History

Please indicate any conditions you have, or are treated for.

1. ◯ Yes ◯ No High blood pressure
2. ◯ Yes ◯ No Heart problems
   Describe:_____
3. ◯ Yes ◯ No Angina (Chest pain)
4. ◯ Yes ◯ No Shortness of breath
5 ◯ Yes ◯ No Lung problems
6. ◯ Yes ◯ No Low blood sugar
7. ◯ Yes ◯ No Cancer
   Where?_____
8. ◯ Yes ◯ No Osteoporosis
9. ◯ Yes ◯ No Rheumatoid arthritis
10. ◯ Yes ◯ No History of neck/back pain
11. ◯ Yes ◯ No Metal implants
    Where?_____
12. ◯ Yes ◯ No Circulation problems
13. ◯ Yes ◯ No Other chronic condition
    Describe:_____

B. Symptoms

Please indicate any symptoms you have.

14. ◯ Yes ◯ No Swelling problem
15. ◯ Yes ◯ No Numbness or tingling
16. ◯ Yes ◯ No Arm or leg weakness
17. ◯ Yes ◯ No Coordination problems
18. ◯ Yes ◯ No Walking difficulty
19. ◯ Yes ◯ No Vertigo experience (a feeling of spinning)
20. ◯ Yes ◯ No Frequent balance loss
21. ◯ Yes ◯ No Falling problems

C. Medications (Please list ALL medications and purpose)

1._____ 4._____
2._____ 5._____
3._____ 6._____

D. Allergic to any medications?

_____
_____

E. Surgeries: (Please list ALL RELATED previous surgeries and approximate date)

1._____
2._____
3._____
4._____

F. Diagnostic Tests: (Please check test for CURRENT problem)

1. X-rays	☐	5. EMG	☐
2. CT Scan	☐	6. Myelogram	☐
3. MRI	☐	7. Other	☐
4. Bone Scan	☐		

G. Have you seen anyone beside you primary physician for you current problem?
Yes ◯ No ◯ Physician's Name _____

EMERGENCY CONTACT
Name:
Phone:
Relationship:
Address:

HOW DID YOU HEAR ABOUT Brewer/Ellsworth P.T.?
_____

CONSENT
I consent to Physical Therapy treatment as prescribed. I understand risks of treatment included. Increased soreness or lack of improvement in my condition. Benefits of treatment include: improvement of my condition (ie. Strength, flexibility, pain relief)

Signature:_____ Date:___/___/___