Health Questionnaire **Maple Leaf Physical Therapy PLLC**

Name: _____ Date: _____

When did your symptoms begin? _____

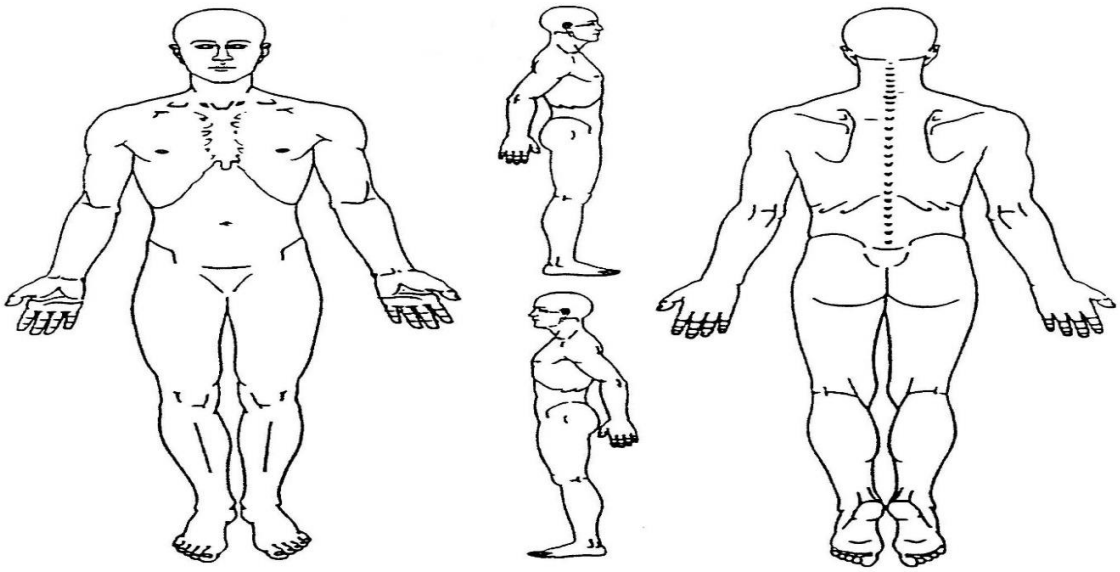
How did your symptoms begin or mechanism of injury? _____

_____

Rate your symptoms on a scale of 0 to 10 (0=no pain and 10=worst pain imaginable):

Current: _____ At best: _____ At worst: _____

Please mark on the diagrams below where you have symptoms:



Circle all that apply: Dull, Sharp, Achy, Throbbing, Numbness, Tingling, Burning, Constant, Occasional

What makes your symptoms worse? (circle all that apply)

Sitting	Standing	Bending	Sleeping	Stairs up/down	Squatting
Driving	Lifting	Reaching	Pushing	Pulling	Stress
Recreation/sports		Household/gardening		In the morning	At night

Other: _____

What makes your symptoms better? (circle all that apply)

Sitting	Standing	Bending	Sleeping	Stairs up/down	Squatting
Driving	Lifting	Reaching	Pushing	Pulling	Stress
Recreation/sports		Household/gardening		In the morning	At night

Other: _____

Have you had similar symptoms or injuries before? Yes or No If yes, how long ago_____

Have you had any imaging (X-ray, MRI, CT scan) done? Yes or No Results: _____

What is your current level of activity/exercise? _____

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Medical History: Please circle all that apply both for current and past issues:

Allergies	Headaches	Pain at night
Anemia	Heart Disease	Pain w/ cough/sneeze
Asthma	Heart Palpations	Polio
Autoimmune Disease	Hernia	Rheumatoid Arthritis
Balance Problems	Hight Blood Pressure	Shortness of Breath
Bowel/bladder changes	Low Blood Pressure	Skin Abnormalities
Cancer	Kidney Problems	Smoking History
Chest Pain	Major illness/Accident	Seizures
Concussion	Migraines	Stroke
Depression or anxiety	Multiple Sclerosis	Thyroid
Diabetes I or II	Numbness/tingling	Urine Leakage
Difficulty sleeping	Osteoarthritis	Vision Problems
Digestive issues	Osteoporosis	Weakness in arms/legs
Dizziness	Pacemaker	Weight changes
Fibromyalgia	Other: _____	

List any previous Surgeries or Hospitalizations with the dates: _____
_____
_____

List any previous Injuries or Orthopedic problems: _____
_____
_____

List current Medications and Supplements: _____
_____
_____

Are there activities that you are unable to do because of your symptoms? _____
_____

What other treatments have you had for this condition? And was it helpful? _____
_____
_____

What are you goals for Physical Therapy? Including what activities you would like to be able to do again:

1. _____
2. _____
3. _____

List any other information that would be helpful for me to know: