PROACTION
PHYSICAL THERAPY

HEALTH QUESTIONAIRE – MEDICARE PATIENTS

Patient Name: _____ DOB: _____ Date of Injury/Accident _____

Rate Your General Health: □ Excellent □ Good □ Fair □ Poor Allergic to Latex? Yes No

□ Male □ Female MUST COMPLETE: HEIGHT: _____ WEIGHT: _____

Circle Current Level of Pain: 0 1 2 3 4 5 6 7 8 9 10 _____

Check conditions (√) you have or have had in the past:

- ○ Anemia
- ○ Back Pain
- ○ Bronchitis
- ○ Drink Alcohol
- ○ Gout
- ○ Hernia
- ○ Parkinson's
- ○ Severe/Frequent Headaches
- ○ Stroke/TA
- ○ Vision Difficulties
- ○ Women's Health Issues
- ○ Diabetes
- ○ Circulatory Problems
- ○ Arthritis
- ○ Pacemaker/Metal Implants
- ○ Angina
- ○ Blood Clot/Emboli
- ○ Coronary Heart Disease
- ○ Emphysema
- ○ Hearing Difficulties
- ○ High Blood Pressure
- ○ Pneumonia
- ○ Sleeping Problems
- ○ Thyroid Problems
- ○ Weakness
- ○ Cancer
- ○ Chest Pains
- ○ Hepatitis B or C
- ○ Allergies
- ○ Asthma
- ○ Bowel/Bladder Problems
- ○ Dizziness or Faintness
- ○ Epilepsy/Seizures
- ○ Heart Attack
- ○ Kidney Disease
- ○ Currently Pregnant
- ○ Smoke Cigarettes
- ○ Varicose Veins
- ○ Weight Loss/Energy Loss
- ○ Depression
- ○ Osteoporosis
- ○ HIV Positive

Please explain any condition checked above: _____

Check each that relates to your medical history:

- ○ Ankle - Both, LT or RT
- ○ Elbow - Both, LT or RT
- ○ Hip - Both, LT or RT
- ○ Knee - Both, LT or RT
- ○ Leg - Both, LT or RT
- ○ Shoulder – Both, LT or RT
- ○ Wrist – Both, LT or RT

Check each that relates to your medical history:

- ○ Joint Replacement
- ○ Pins or Metal Implant
- ○ Arthritis
- ○ Numbness/Tingling/Neuropathy

Check each that relates to your medical history:

- ○ Complex regional pain syndrome
- ○ I have received P.T. treatment at home
- ○ I am a caregiver for someone else
- ○ Other important issues
- ○ My home has stairs
- ○ Cancer
- ○ I use a cane
- ○ I use a walker
- ○ Pelvic Floor
- ○ Diabetes, Type 2
- ○ I use a wheelchair
- ○ Infectious Disease
- ○ Other surgery
- ○ Diabetes, Type 1
- ○ I live alone
- ○ Incontinence
- ○ Vertigo/Balance

Does your diagnosis impact your ability to do your job?

- ○ I am retired
- ○ I can work, but with great difficulty
- ○ I can work, with minor difficulty
- ○ The diagnosis prevents me from working
- ○ The diagnosis does not impact my ability to work
- ○ Not Applicable
- ○ I can only work part time

Does your diagnosis impact your ability to attend school?

- ○ **The diagnosis prevents me from attending school**
- ○ **I am in school, but the diagnosis has a big impact**
- ○ **I am in school and the diagnosis has a minor impact**
- ○ **School is normal, but I can't participate in sports**
- ○ **School is normal, no impact**
- ○ **Not Applicable**

How often do you exercise?

- ○ **Never**
- ○ **Usually once per week**
- ○ **Usually twice per week**
- ○ **Usually 3 times per week**
- ○ **4 or more times per week**

Does your daily routine or work aggravate your injury?

- ○ **NO**
- ○ **I am unable to participate in my normal routines or work**
- ○ **My routine/work usually impacts my injury 1 day per week**
- ○ **My routine/work aggravates my injury about 2 days per week**
- ○ **My routine/work aggravates my injury 3 or more days per week**
- ○ **My routine/work aggravates my injury every day, but I try to cope**

Medical History: ARTHRITIS - Check all that relates.

○ **Toes**	**LT**	**RT**	**Both**	○ **Hip**	**LT**	**RT**	**Both**	○ **Neck/Spine**	**LT**	**RT**	**Center**
○ **Ankle**	**LT**	**RT**	**Both**	○ **Fingers**	**LT**	**RT**	**Both**				
○ **Calf**	**LT**	**RT**	**Both**	○ **Wrist**	**LT**	**RT**	**Both**				
○ **Knee**	**LT**	**RT**	**Both**	○ **Arm**	**LT**	**RT**	**Both**				
○ **Thigh**	**LT**	**RT**	**Both**	○ **Shoulder**	**LT**	**RT**	**Both**				

Medical History: JOINT REPLACEMENT - Check all that relates.

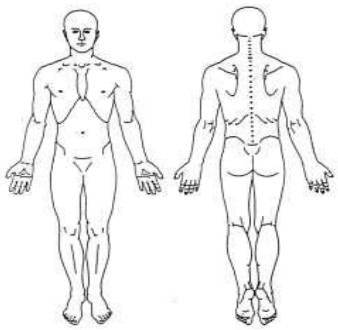
○ **Toes**	**LT**	**RT**	**Both**	○ **Hip**	**LT**	**RT**	**Both**	○ **Neck/Spine**	**LT**	**RT**	**Center**
○ **Ankle**	**LT**	**RT**	**Both**	○ **Fingers**	**LT**	**RT**	**Both**				
○ **Calf**	**LT**	**RT**	**Both**	○ **Wrist**	**LT**	**RT**	**Both**				
○ **Knee**	**LT**	**RT**	**Both**	○ **Arm**	**LT**	**RT**	**Both**				
○ **Thigh**	**LT**	**RT**	**Both**	○ **Shoulder**	**LT**	**RT**	**Both**				

Medical History: NUMBNESS/TINGLING/NEUROPATHY - Check all that relates.

○ **Toes**	**LT**	**RT**	**Both**	○ **Hip**	**LT**	**RT**	**Both**	○ **Neck/Spine**	**LT**	**RT**	**Center**
○ **Ankle**	**LT**	**RT**	**Both**	○ **Fingers**	**LT**	**RT**	**Both**				
○ **Calf**	**LT**	**RT**	**Both**	○ **Wrist**	**LT**	**RT**	**Both**				
○ **Knee**	**LT**	**RT**	**Both**	○ **Arm**	**LT**	**RT**	**Both**				
○ **Thigh**	**LT**	**RT**	**Both**	○ **Shoulder**	**LT**	**RT**	**Both**				

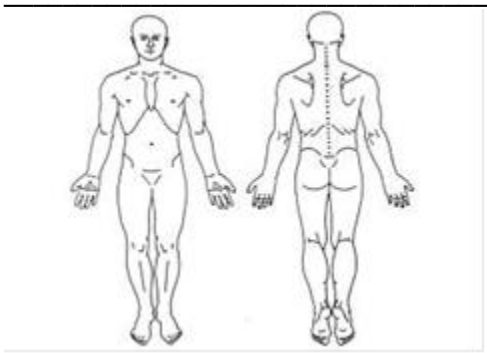
Medical History: PINS/METAL IMPLANT - Check all that relates.

○ **Toes**	**LT**	**RT**	**Both**	○ **Hip**	**LT**	**RT**	**Both**	○ **Neck/Spine**	**LT**	**RT**	**Center**
○ **Ankle**	**LT**	**RT**	**Both**	○ **Fingers**	**LT**	**RT**	**Both**				
○ **Calf**	**LT**	**RT**	**Both**	○ **Wrist**	**LT**	**RT**	**Both**				
○ **Knee**	**LT**	**RT**	**Both**	○ **Arm**	**LT**	**RT**	**Both**				
○ **Thigh**	**LT**	**RT**	**Both**	○ **Shoulder**	**LT**	**RT**	**Both**				



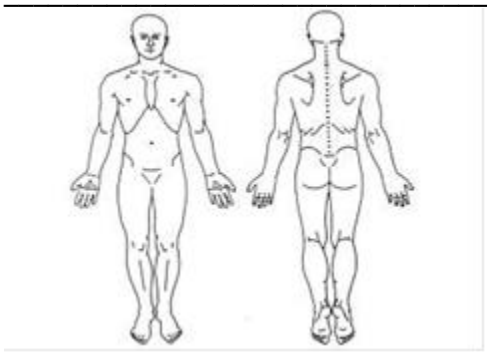
Check below what prompted TODAY'S visit:

- ○ **Ankle, LT**
- ○ **Ankle, RT**
- ○ **Arm, LT**
- ○ **Arm, RT**
- ○ **Buttock, LT**
- ○ **Buttock, RT**
- ○ **Chest, LT**
- ○ **Chest, RT**
- ○ **CRPS, LT**
- ○ **CRPS, RT**
- ○ **Elbow, LT**
- ○ **Elbow, RT**
- ○ **Feet/Toes, LT**
- ○ **Feet/Toes, RT**
- ○ **Forearm, LT**
- ○ **Forearm, RT**
- ○ **Hands/Fingers, LT**
- ○ **Hands/Fingers, RT**
- ○ **Head, LT**
- ○ **Head, RT**
- ○ **Hip, LT**
- ○ **Hip, RT**
- ○ **Incontinence**
- ○ **Jaw, LT**
- ○ **Jaw, RT**
- ○ **Knee, LT**
- ○ **Knee, RT**
- ○ **Lower Back, Center**
- ○ **Lower Back, LT**
- ○ **Lower Back, RT**
- ○ **Neck, LT**
- ○ **Neck, RT**
- ○ **Pelvic Floor**
- ○ **Shin/Calf, LT**
- ○ **Shin/Calf, RT**
- ○ **Shoulder, LT**
- ○ **Shoulder, RT**
- ○ **Spine**
- ○ **Thigh, LT**
- ○ **Thigh, RT**
- ○ **Upper Back, Center**
- ○ **Upper Back, LT**
- ○ **Upper Back, RT**
- ○ **Vertigo/Balance**
- ○ **Wrist, LT**
- ○ **Wrist, RT**



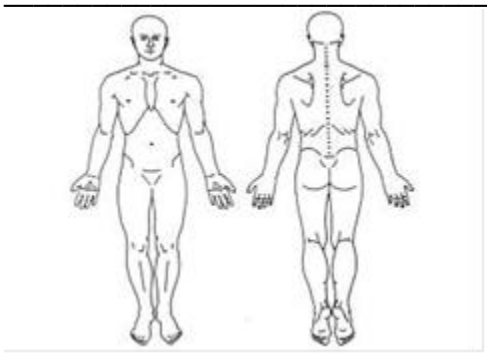
Is this a reoccurrence of a prior injury? ○ **Yes** ○ **NO**

If yes, what year was the prior injury? _____



Describe what type of pain you feel:

- ○ **Aching**
- ○ **Burning**
- ○ **Constant**
- ○ **Cramping**
- ○ **Deep**
- ○ **Dull**
- ○ **Heavy**
- ○ **Numbness**
- ○ **Stabbing**
- ○ **Throbbing**
- ○ **Variable**
- ○ **Weak**
- ○ **Pins and Needles**



What was your level of pain when the injury first occurred?

0	1	2	3	4	5	6	7	8	9	10

None **Worst**

What is your pain level when it is at its worst?

0	1	2	3	4	5	6	7	8	9	10

None **Worst**

What is your pain level when you feel best?

0	1	2	3	4	5	6	7	8	9	10

None **Worst**

What makes your pain worse?

○ Reaching Back	○ Lying Flat	○ Getting up out of bed	○ Dressing and grooming
○ Cooking	○ Carrying items	○ Climbing stairs	○ Twisting
○ Lifting anything	○ Lifting heavy weights	○ Pulling	○ Raising arm over the head
○ Looking up/down	○ Walking		

What relieves your pain?

○ Ice ○ Heat ○ Stretching ○ Exercise ○ Pain Medication ○ Lying Flat ○ Avoid activity ○ Nothing

FALLS:

How many times have you fallen in the past year? _____ Were you injured? ○ Yes ○ No

TOBACCO:

Do you: ○ Smoke Tobacco ○ Chew Tobacco ○ Snuff Tobacco ○ All Above ○ None Above

Have you ever received advice or counseling to help you stop using tobacco?

○ Yes, I have received advice or counseling ○ No, I have not received advice or counseling

List Any None or Prescription Drugs/Supplements:

Medication Name	Dosage	Reason for taking
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____

Current or Past Surgeries: **To the same area:** □ Yes □ No

_____
_____
_____
_____

Signature: _____ **Date _____**

Your Medical History is very important. By signing, you acknowledge that the above information is accurate and true.

ALL information on this health questionnaire form must be COMPLETED signed and dated.