Northern Arizona Healthcare
EntireCare Rehab & Sports Medicine
Flagstaff Medical Center • Verde Valley Medical Center

Patient History Questionnaire – Physical Therapy

Name:_____ **Date:**_____

Phone:_____ **Date of injury:**_____

Email: _____**.com**

Primary care provider:_____

1. Reason for visit today: _____

2. Leisure activities: _____

3. Do you have allergies? If yes, please list:_____

4. Have you ever been diagnosed as having any of the following conditions? (Circle all that apply)

Heart problems:	Yes	No	Rheumatoid Arthritis:	Yes	No	Stroke:	Yes	No
Thyroid problems:	Yes	No	Chemical dependency:	Yes	No	Epilepsy:	Yes	No
Multiple Sclerosis:	Yes	No	Breathing problems:	Yes	No	Arthritis:	Yes	No
Tuberculosis:	Yes	No	High blood pressure:	Yes	No	Diabetes:	Yes	No
Kidney disease:	Yes	No	Circulation problems:	Yes	No	Anemia:	Yes	No
Osteoporosis:	Yes	No	Osteoarthritis:	Yes	No	Hepatitis:	Yes	No
Cancer:	Yes	No	Depression/Anxiety:	Yes	No	Blood clots	Yes	No
What kind: _____			Lymphedema:	Yes	No	Other:_____		

5. Please list any surgeries or other conditions for which you have been treated, including the approximate date and reason for the surgery/treatment:

Date:	Reason:
___-___-___	_____
___-___-___	_____

6. Have you recently had any of the following diagnostic studies? (Circle all that apply and add date)

X-Ray ___-___-___ CT scan: ___-___-___ MRI: ___-___-___

EMG: ___-___-___ Injection: ___-___-___ Other: ___-___-___

7. Please list any prescription medications you are taking: (including pills, injections and/or skin patches)

_____ _____

_____ _____

PLEASE SEE OTHER SIDE →

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8. Rate your pain on a 0-10 scale (0 = no pain and 10 = worst possible pain):_____

9. Rate your stress level on a 0-10 scale (0 = no stress and 10 = greatest stress):_____

10. Is your pain:

Worse in the morning ____	Worse by the end of the day____
Better in the morning_____	Better by the end of the day_____