



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 _____