Kittitas Valley Healthcare
Your Home for Health

Physical Therapy Patient - Initial Health Questionnaire

Patient Name _____ DOB _____ Age _____ Today's Date _____

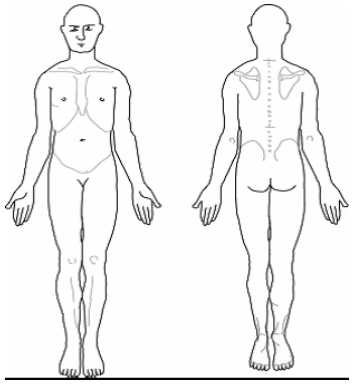
Referring Physician _____ Other/Primary Physician _____

1. For which problem(s) are we seeing you today? _____

_____

2. When did the symptoms start? _____

3a. Please mark where you have symptoms on the picture to the right.



3b. Please mark your symptoms:

☐ Constant (24 hours/day)	☐ Falling	☐ Knife-like
☐ Intermittent (comes & goes)	☐ Fear of falling	☐ Burning
☐ Dizziness	☐ Sharp	☐ Pins and needles
☐ Vertigo	☐ Dull	☐ Numbness
☐ Lightheadedness	☐ Aching	☐ Other:
☐ Imbalance	☐ Throbbing	_____

4. Please check the rating that best describes your symptoms:

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
No symptoms		*Mild symptoms, annoying*		*Nagging, uncomfortable, troublesome*		*Miserable, distressing*		*Intense, dreadful, horrible*		*Worse symptoms possible, unbearable*

5. How do your symptoms vary over a 24-hour period?

Morning _____ Noon _____

Evening _____ Night _____

6. What activities increase your symptoms? _____

7. What activities decrease your symptoms? _____

8. Because of your problem, you have difficulty with the ability to:

☐ Walk	☐ Move quickly	☐ Turn	☐ Throw
☐ Roll in/get out of bed	☐ Bend over	☐ Look up	☐ Get in/out of car
☐ Squat	☐ Use stairs	☐ Jog	☐ Drive
☐ Reach behind back	☐ Reach overhead	☐ Carry objects	☐ Other: _____

9. Describe any treatment you've had for the same problem/symptoms: _____

_____

10. Describe any diagnostic testing (x-rays, MRI, CT tests) done for your current problem: _____

_____

Please complete both sides of form.

KVH Physical Therapy | Initial Health Questionnaire, Cont.

11. What is your goal for physical therapy treatment? _____

12. Occupation: _____ 13. You live with: ☐self ☐spouse ☐family ☐other

14. Have you recently noticed any of the following?

	Yes	No	Comments
Change in hearing, noise in ears	☐	☐	
Unexpected weight loss / gain	☐	☐	
Nausea / vomiting	☐	☐	
Unexplained fatigue	☐	☐	
Weakness	☐	☐	
Fever, chills, sweat	☐	☐	
Fainting spells	☐	☐	
Incontinence (of urine or stool)	☐	☐	

15. Please list previous surgeries, fractures, or serious injuries, with approximate dates: _____

16. Have you been diagnosed with any of the following conditions? Check any that apply.

☐Recent infection	☐Bowel or bladder problems	☐Osteoporosis	☐Tuberculosis
☐High blood pressure	☐Kidney problems	☐Depression or anxiety	☐Headaches
☐Diabetes (with or without neuropathy)	☐Thyroid problems	☐Arthritis (RA/rheumatoid, osteoarthritis)	☐Are you pregnant?
☐Heart problems	☐Breathing difficulties	☐Dizziness or vertigo	☐Other:
☐Stroke/TIA	☐Seizures	☐Multiple Sclerosis	
☐Cancer	☐Frequent falls	☐Hepatitis	

17. Please list all current medications, including over-the-counter and supplements. Attach another sheet if needed.

18. Have you ever taken any of these for an extended period of time? (Mark all that apply.)

☐Steroids ☐Blood thinners ☐IV antibiotics If yes, please explain: _____

19. Please list any allergies to latex, adhesives or medications: _____

20. Do you have any metal imlpants (pins/plates, pacemaker)? _____

21. Have you ever been in a car accident? If so, list dates/injuries: _____

22. Is the problem you are being treated for involved in litigation (lawsuit)? ☐Yes ☐No

23. How do you learn best? ☐Pictures ☐Written ☐Verbal ☐Documentation

24. Is there anything else you would like to tell us about your problem? _____

THIS SECTION COMPLETED BY CLINIC STAFF

KVH Occupational Therapist Reviewing Questionnaire *Date*