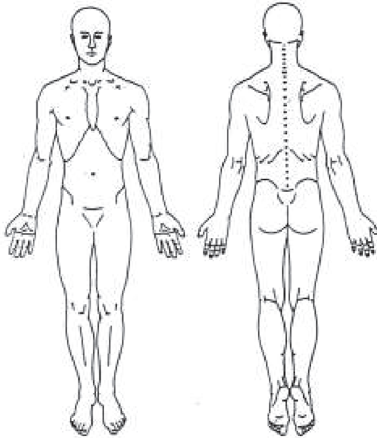
HEALTH QUESTIONNAIRE

Patient Name: ________________________________ Date of Birth: ____________

Rate your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Male ☐ Female ☐ Maximum Level of Pain: 0 1 2 3 4 5 6 7 8 9 10
(no pain) (max pain)



Please mark on the diagrams the areas where you feel pain.

Current Complaint ____

When did your symtomps start? _____________________________________

Condition due to: ☐ car accident ☐ work injury ☐ other

What makes you feel better? ____

What makes you feel worse? ____

Symptoms are: ☐ constant ☐ intermittent ☐ improving
☐ getting worse ☐ about the same
☐ worse in AM ☐ worse in PM ☐ same throughout the day

Describe your pain as: ☐ dull ☐ aching ☐ sharp ☐ burning

Do you have any numbness or tingling? ☐ Yes ☐ No

Does your pain awaken you at night? ☐ Yes ☐ No

Are you allergic to Latex? ☐ Yes ☐ No Other allergies: ______________________________

IMPORTANT WOMEN: Is there any chance you may be pregnant? ☐ Yes ☐ No

Please list 3 important activities that you are unable to do or having difficulty with as a result of your problem:

1. ____
2. ____
3. ____

Previous Injuries:

____

____

Current or Past Surgeries:

____

____

List any non- or prescription drugs/supplements (medication name, dosage and reason for taking):

____

For medical and insurance purposes, please choose what applies:

Have you had previous physical therapy? ☐ No ☐ Yes When ?_____________________________

If yes: ☐ For the same condition? ☐ Different condition?_____________________________

Signature: ________________________________ Date ______________________________