Neil King Physical Therapy
HEALTH QUESTIONNAIRE

DATE: _______________

NAME: ______________________________ **STREET** ___________________________ **Cell #** ________________

CITY_________________ **STATE** __________ **ZIP** _________**PH#**________________ **WK#**_______________

OCCUPATION: __________________ **DOB:** ____/____/____ **SS#** ______________________________________

PHYSICIAN: _________________________________ **PHONE:** (____) ________-___________

EMPLOYER NAME ____

EMP. ADDRESS ____**EMP. PHONE** (   ) __________________

INSURANCE CARDHOLDER'S DATE OF BIRTH ____

HAVE YOU EVER HAD OR BEEN TOLD YOU HAD: (CHECK IF YES)

___ **HEART OR ARTERY DISEASE**
___ **DIABETES**
___ **GENITO-URINARY PROBLEMS**
___ **EYE, EAR, NOSE, OR THROAT DISORDER**
___ **RESPIRATORY DISORDER**
___ **HIGH BLOOD PRESSURE**
___ **CANCER OR ANY TYPE OF MALIGNANCY**
___ **ULCER OR DIGESTIVE DISORDER**
___ **VARICOSE VEINS**
___ **EPILEPSY**
___ **BIRTH DEFECT OF ANY TYPE**
___ **GOUT**
___ **CHEST PAINS**

EXPLAIN IF YES:

____

____

YOUR PRESENT WEIGHT:____________ **HEIGHT** __________

WHAT IS YOUR REASON FOR SEEKING THERAPY AT THE PRESENT TIME? ______________________

____

LIST ALL PRESCRIPTION MEDICINES YOU ARE CURRENTLY USING: ____________________________

____

LIST ANY DIAGNOSTIC TESTING YOU HAVE HAD FOR THIS INJURY/CONDITION (i.e., x-rays, MRI)

____

HAVE YOU EVER HAD THERAPY IN THE PAST FOR THIS INJURY/CONDITION? IF SO, WHEN?

____

DO YOU HAVE ANY DIFFICULTY IN YOUR DAILY LIVING WITH: (CIRCLE IF YES)

WALKING	**PERSONAL HYGIENE**
STANDING	**REACHING**
SITTING	**LIFTING**
SLEEPING	**CARRYING MORE THAN:**
BATHING	**FIVE POUNDS TEN POUNDS**
DRESSING	**OTHER: ______________________**
	______________________________

DO YOU HAVE PROBLEMS WITH ANY OF THE FOLLOWING: (CIRCLE IF YES)

HEADACHES	**ENDOMETRIOSIS**
TMJ	**ABDOMINAL ADHESIONS**
MENSTRUAL CRAMPING	**FIBROID TUMORS**
IRREGULAR PERIODS	**ABDOMINAL PAIN**
	OTHER: ______________________
	______________________________

PLEASE RATE YOUR LEVEL OF PAIN WHEN YOU FEEL YOUR BEST ON A 0-10 SCALE (0=NO PAIN, 10 IS THE WORST PAIN)______. RATE YOUR PAIN WHEN YOU FEEL YOUR WORST______. LIST YOUR PAIN LEVEL AT THIS MOMENT______.

PLEASE DESCRIBE YOUR ACTIVITY LEVEL PRIOR TO THIS INJURY/CONDITION:

____

ARE YOU PREGNANT? _______

DO YOU CURRENTLY HAVE ANY ILLNESSES? ____

PLEASE LIST ALL OPERATIONS, SERIOUS ILLNESSES, INJURIES, OR BROKEN BONES THAT YOU HAVE SUSTAINED:

____

____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE:

____

____

SIGNED: ____________________________________