Name: ____

WESTARM PHYSICAL THERAPY

Initial Questionnaire

EMERGENCY CONTACT

Emergency Contact Name: ____

Telephone Number: ______________________ Relationship to Patient: ______________

PHYSICAN / PROVIDER INFORMATION

Referring Physician: ____

Date returning to the doctor: ____

Have you had prior treatment for this condition?

____

____

Are you receiving ANY home health services (PT, OT, Speech, Nursing)? _______ Yes _______ No

EMPLOYMENT DETAILS

Work Status: _____ Full Time _____ Part Time _____ Disabled _____ Retired

Profession: ____

MEDICAL DETAILS

Please indicate if you have had or currently have any of the following medical conditions. (Check all that apply)

- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Back / neck pain
- ☐ Blood clots
- ☐ Cancer
- ☐ Chest Pain
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy / Seizures
- ☐ Face / Ear / Jaw Pain
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ High blood pressure
- ☐ HIV+ / AIDS
- ☐ Hearing loss
- ☐ Imbalance
- ☐ Incontinence
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraines
- ☐ Multiple Sclerosis (MS)
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Polio
- ☐ Pregnant (currently)
- ☐ Rheumatoid Arthritis
- ☐ Shortness of breath
- ☐ Skin condition
- ☐ Stroke / TIA
- ☐ Swelling in the feet / legs
- ☐ Tuberculosis
- ☐ Vestibular Neuritis
- ☐ None of the above
- ☐ Other: ____

Are you currently experiencing or have experienced in the recent past any of the following symptoms?

- ☐ Chest Pain / Heart Palpitations
- ☐ Difficulty Swallowing
- ☐ Dizziness / Blackouts
- ☐ Fever / Chills / Sweats
- ☐ Loss of Balance / Coordination
- ☐ Shortness of Breath
- ☐ Urinary or Bowel Problems
- ☐ Vomiting / Nausea
- ☐ Weakness in the arms and legs
- ☐ Weight Gain
- ☐ NONE OF THE ABOVE
- ☐ Other: ____

Name: ____

Please indicate any medications you are currently taking: ______________________________________

____

____

Please indicate any history of surgical procedures: ____

____

____

Please list anything you may be allergic to: ____

____

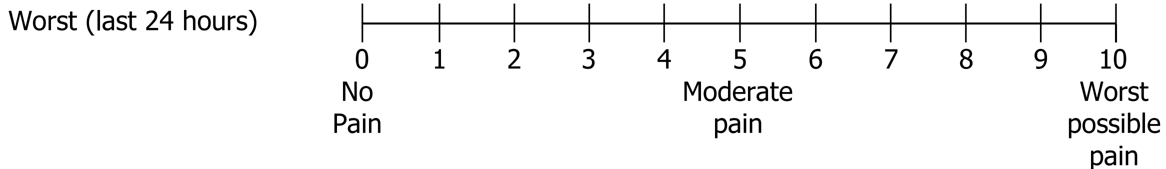
HISTORY OF PRESENT COMPLAINTS

What are your symptoms / complaints? ____

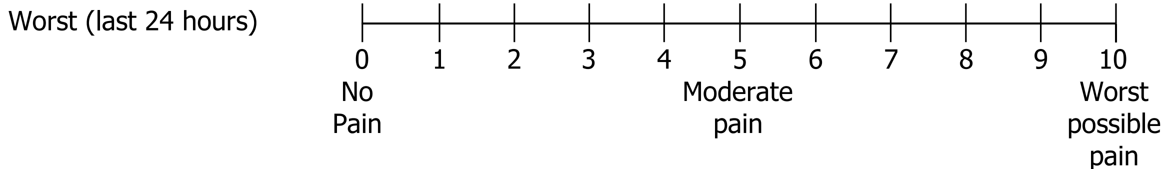
Date of injury: _________________________ Date of surgery (if applicable): ________________

Site of Pain: __________________________

Pain intensity at rest



Pain intensity during activity



Onset of Pain: _______ Sudden _______ Gradual

Have you had any of the following **diagnostic** tests for this condition?

☐ None ☐ MRI ☐ Bone Scan ☐ EMG
☐ X-rays ☐ Arthrogram ☐ Fluoroscope ☐ Nerve Conduction
☐ CT scan ☐ Vestibular ☐ Other: ______________________________