



Women's Center for Wellness and Rehabilitation

Evaluation for Orthopedic issues

DEMOGRAPHIC AND INSURANCE INFORMATION (PHYSICAL THERAPY DEPARTMENT)

PHYSICAL THERAPY GENERAL HEALTH QUESTIONNAIRE

Name: _____ Why are you here? _____

Check all the Conditions that apply to you:

HEART/CIRCULATION	v	MEDICAL PROBLEMS	v
Heart Disease		Diabetes	
<input checked="" type="checkbox"/> High Blood Pressure		Fainting Spells	
Pacemaker		Cancer	
Heart Surgery		<input checked="" type="checkbox"/> Dizziness	
Pain/tightness in chest		Thyroid Problems	
<input checked="" type="checkbox"/> Stroke		<input checked="" type="checkbox"/> Falls the last 6 mos.	
BONES & JOINTS		<input checked="" type="checkbox"/> # trips/slips/near falls	
Osteoporosis		<input checked="" type="checkbox"/> Depression	
Scoliosis		LUNG/BREATHING	
Fibromyalgia		Difficulty breathing	
Plantar fasciitis		Shortness of Breath	
Dropped arches/flat feet		Smoke cigarettes now	
<input checked="" type="checkbox"/> Numbness in feet/legs		History of smoking	
Tailbone fracture		SURGICAL HISTORY	
Joint Replacements		Back or neck	
Swelling in Ankles/feet		Tubal Ligation	
AREAS OF PAIN		Laproscopy	
Back ("sciatica like pain")		Abdominal Hysterectomy	
Neck		Vaginal Hysterectomy	
Ribs		Gall Bladder	
Shoulders		Bladder surgery	
Abdomen/belly		FAMILY HISTORY	
Tailbone		Heart Disease	
Wrist ("carpal tunnel")		High Blood Pressure	
Swelling in the hands		Diabetes	
Feet		Cancer	
Knees		Stroke	
Hips		Osteoporosis	
Other			

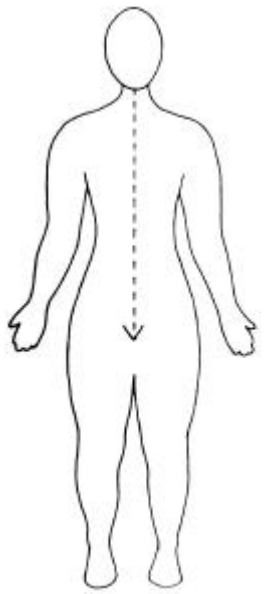
LIST ALL THE MEDICATIONS YOU ARE TAKING, INCLUDING HERBAL AND OVER THE COUNTER MEDICATIONS:

Name of Medication	For what?	Name of Medication	For What?

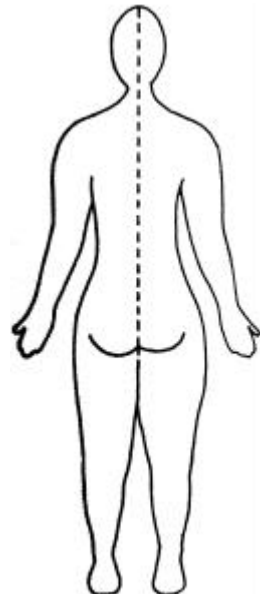


TELL US ABOUT YOUR PAIN

Please mark with an "X" where your pain begins. Shade any other areas of pain



FRONT



BACK

CHECK ALL THE WORDS THAT DESCRIBE YOUR PAIN:

Numb Stabbing Burning Irritating Aching Throbbing Tender Unbearable Shooting
 Sharp Constant Other _____

WHAT MAKES YOUR PAIN WORSE?

Sitting standing Walking Getting out of bed exercise sexual intercourse menses
 Getting up from sitting position Working at home all day Being at work all day Exercise
 Other _____

WHAT MAKES YOUR PAIN BETTER?

Heating pad Ice pack Resting in bed Resting in Chair walking Medication Exercise
 Other _____

CHECK ALL THE STATEMENTS THAT ARE TRUE:

I have numbness or tingling in my legs I have numbness or tingling in my arms or hands
 There is a change in the way my bladder or bowels work since this problem started
 I feel dizzy I have blurred vision.

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? None or:

TREATMENTS	HAS IT HELPED?	TREATMENTS	HAS IT HELPED?
Medication(s)	Yes No A little	Physical Therapy	Yes No A little
Chiropractic	Yes No A little	Other	Yes No A little
Surgery	Yes No A little	Other	Yes No A little