

# Amity Physical Therapy

## Health Questionnaire

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Date of injury or onset of current problem: \_\_\_\_\_

How did this problem develop?

\_\_\_\_\_  
\_\_\_\_\_

Have you ever injured this area before? Yes No Date: \_\_\_\_\_

Circle any tests you have had for this problem: X-Ray MRI CT scan EMG Blood  
Bone density Other \_\_\_\_\_

Current Medications: 1. \_\_\_\_\_ 4. \_\_\_\_\_  
2. \_\_\_\_\_ 5. \_\_\_\_\_  
3. \_\_\_\_\_ 6. \_\_\_\_\_

Occupation: \_\_\_\_\_ Last Day Worked \_\_\_\_\_

Do you smoke? Yes No Packs/day \_\_\_\_\_ Drink alcohol? Yes No How often? \_\_\_\_\_

**Please check Yes (Y) or No (N) if you have ever had any of the following:**

<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Emotional Disorders	<input type="checkbox"/> Orthopedic Surgery (explain)
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Unexplained Weight Loss
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Unexplained Weight Gain
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Infections (type) _____	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Anemia	<input type="checkbox"/> Low Back or Joint Pain	<input type="checkbox"/> Night Sweats
<input type="checkbox"/> Lung Conditions	<input type="checkbox"/> Fainting/Dizziness	<input type="checkbox"/> Unusual Swelling/Edema
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Allergies to _____	<input type="checkbox"/> Unusual fatigue symptoms
<input type="checkbox"/> Bladder Disease	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Hospitalization (explain)
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Hernia	<input type="checkbox"/> Cancer (type) _____
<input type="checkbox"/> Diabetes x _____ years	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Other _____

### Surgical Procedures:

### Hospitalizations:

<u>Procedure:</u>	<u>Date:</u>	<u>Explain:</u>	<u>Date:</u>
1. _____	_____	1. _____	_____
2. _____	_____	2. _____	_____
3. _____	_____	3. _____	_____
4. _____	_____	4. _____	_____