

Oakdale Physical Therapy and Fitness

Patient Questionnaire

Patient Name _____ DOB _____ Age _____ Email _____

Address _____ City _____ State _____ Zip _____

Phone: Work _____ Home _____ Cell _____

Currently Working? Yes/No _____ Hours/week? (#) _____ Working positions: _____%standing _____%walking _____%sitting

Occupation: _____ Employer: _____ Court Jester Member: Yes/No _____

Past work history/duration _____

Are you **currently** receiving **Home Care** or **PT elsewhere**? Yes/No, Where: _____

Referring Physician _____ Primary Care Physician _____

When is your next Dr's appt. (date)? _____

How did you hear about Oakdale PT & Fitness? Physician's Office TV Phonebook Website

Because you are a Court Jester member: West or East? (circle one)

Other _____ Word of mouth (Name) _____

Past/Present medical conditions (circle):

Asthma	No/Past/Present/Family	Epilepsy/Seizures	No/Past/Present/Family	Kidney Disease	No/Past/Present/Family
Arthritis	No/Past/Present/Family	Extremity Swelling	No/Past/Present/Family	Metal/Other implants	No/Past/Present/Family
Bowel Dysfunction	No/Past/Present/Family	Fainting	No/Past/Present/Family	Multiple Sclerosis	No/Past/Present/Family
Cancer	No/Past/Present/Family	Fever/Chills	No/Past/Present/Family	Osteopenia/Osteoporosis	No/Past/Present/Family
Chemical Dependency	No/Past/Present/Family	Fibromyalgia	No/Past/Present/Family	Pacemaker	No/Past/Present/Family
Chest Pain/Discomfort	No/Past/Present/Family	Fracture	No/Past/Present/Family	Pregnancy	No/Past/Present/Family
Circulatory Disease	No/Past/Present/Family	Headache	No/Past/Present/Family	Shortness of Breath	No/Past/Present/Family
Depression	No/Past/Present/Family	Hearing Implants	No/Past/Present/Family	Stroke	No/Past/Present/Family
Diabetes	No/Past/Present/Family	Heart Attack	No/Past/Present/Family	Thyroid Problems	No/Past/Present/Family
Diarrhea	No/Past/Present/Family	Heart Disease	No/Past/Present/Family	Visual Impairments	No/Past/Present/Family
Dizziness	No/Past/Present/Family	Hepatitis	No/Past/Present/Family	Unexplained weight change	No/Past/Present/Family
Difficulty Urinating	No/Past/Present/Family	Hernia	No/Past/Present/Family	Urinary frequency changes	No/Past/Present/Family
Eating Disorder	No/Past/Present/Family	High Blood Pressure	No/Past/Present/Family	Other _____	No/Past/Present/Family
Emphysema	No/Past/Present/Family	Infectious Disease	No/Past/Present/Family	Other _____	No/Past/Present/Family

Comments: _____

Other Medical History (Sprains, fractures, illnesses, etc): _____

Surgical History (Procedures and Dates): _____

Medications / supplements (Include current list and past long-term use): _____

Allergies and Reactions: Check here if none _____

Do you use: Tobacco Yes/No Frequency _____ Caffeine Yes/No Freq _____ Alcohol Yes/No Freq _____

Current Condition:

What injury / problem / complaint has brought you to physical therapy today: _____

When and how did this problem begin: _____

Describe your pain: ___ Constant ___ Intermittent ___ Dull ___ Sharp ___ Burning ___ Other: _____

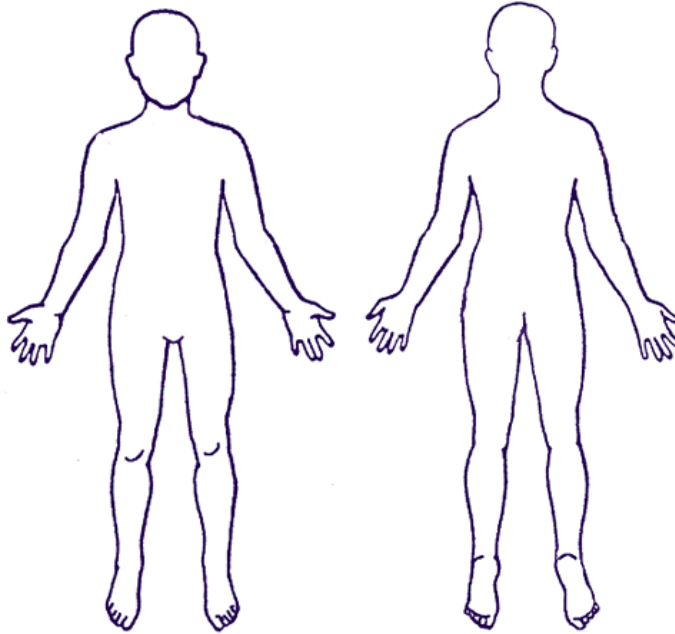
Rate your pain levels using (0-10) (0=none, 10=unbearable): At worst _____ At best _____ Right now _____

What makes it better: _____ Worse: _____

Location of pain: _____

Please use diagrams to indicate where you feel symptoms right now.

KEY:
Pins & Needles = 00000
Stabbing = /////
Burning = XXXXX
Deep Ache = ZZZZZ



What treatments have you received to address this condition (injections, medication, surgery, etc.): _____

X-Ray Y/N: When/Where _____ MRI: Y/N When/Where _____ CT Scan: Y/N When/Where _____

How does this condition affect or limit you on a day to day basis: _____

Prior to this problem, what was your normal activity level (recreation, sports, hobbies, exercise): _____

What are your goals in physical therapy: _____

Therapist Signature: _____ Date: _____

Therapist Notes: _____