

KITTITAS VALLEY PHYSICAL THERAPY  
PATIENT INITIAL HEALTH QUESTIONNAIRE

Name: \_\_\_\_\_

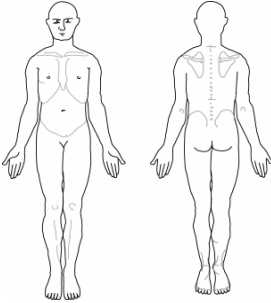
Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

1. For which problem(s) are we seeing you today? \_\_\_\_\_  
\_\_\_\_\_

2. When did the symptoms start? \_\_\_\_\_

3. Please mark where you have symptoms on the picture below. Also mark any areas of numbness/tingling or other unusual sensations:



Please circle/describe your symptoms:

Constant (24 hours/day)

Intermittent (comes and goes)

Sharp

Dull

Aching

Throbbing

Knife-like

Burning

Pins and Needles

Numbness

Other: \_\_\_\_\_

4. How do your symptoms vary over 24 hour period? Morning \_\_\_\_\_

Noon \_\_\_\_\_

Evening \_\_\_\_\_

Night \_\_\_\_\_

5. Please circle what best describes your pain range:

0	1	2	3	4	5	6	7	8	9	10
No pain		Mild Pain, Annoying		Nagging Pain,		Miserable, Distressing		Intense, Dreadful,		Worse Pain
No Hay Dolor		Dolor Minimo		Uncomfortable,		Dolor Severo		Horrible		Possible,
				Troublesome				Dolor Muy Severo		Unbearable
				Dolor Moderado						El Dolor Mas
										Agudo Que Hay

7. Since your problem(s) started, are your symptoms getting: Better Worse Not Changing

8. What activities increase your symptoms: \_\_\_\_\_

9. What activities decrease your symptoms: \_\_\_\_\_

10. Have you had any x-rays, MRI, or CT tests done for your current diagnosis? \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

11. Are you currently being treated for other diagnoses or medical problems? \_\_\_\_\_

12. If you smoke, how many packs a day do you smoke? \_\_\_\_\_

13. If you drink alcohol, how many glasses of alcohol do you drink/week? \_\_\_\_\_

14. If you exercise, how many days/week do you exercise? \_\_\_\_\_

15. How do you learn best? \_\_\_\_\_ verbal \_\_\_\_\_ in writing \_\_\_\_\_ demonstration

PLEASE COMPLETE BOTH SIDES

15. Have you recently noticed any of the following?

	Yes	No	Comments
Unexplained Weight Loss/Gain			
Nausea/Vomiting			
Unexplained Fatigue			
Weakness			
Fever, Chills, Sweat			
Fainting Spells			
Incontinence (of urine or stool)			

16. Have you ever been diagnosed with any of the following conditions?

	Yes	No		Yes	No
High Blood Pressure			Rheumatoid Arthritis		
Diabetes			Osteoporosis		
Heart Problems			Seizures		
Kidney Problems			Depression		
Cancer			Dizziness		
Bowel or Bladder Problems			Multiple Sclerosis		
Asthma			Hepatitis / Tuberculosis (Circle)		
Breathing Difficulties			Frequent Falls		
Thyroid Problems			Headaches		
Stroke			Other:		

17. Please list all current medications (including over-the-counter medications and supplements)—(You may attach another sheet if necessary): \_\_\_\_\_

18. Have you ever taken steroids or blood thinners for an extended period of time? YES NO  
If YES, please explain: \_\_\_\_\_

19. Please list any allergies to latex, adhesives, or medications you might have: \_\_\_\_\_  
\_\_\_\_\_

20. Please list previous surgeries, fractures, or serious injuries with approximate dates: \_\_\_\_\_  
\_\_\_\_\_

21. Have you ever been involved in a car accident? YES NO Date: \_\_\_\_\_ Injuries: \_\_\_\_\_

22. Do you have any metal implants in your body (pins/plates, pacemaker)? \_\_\_\_\_

23. For women: Are you pregnant? YES NO If yes, how many months? \_\_\_\_\_

24. Is the problem you are being treated for involved in litigation (lawsuit)? YES NO

\_\_\_\_\_  
Therapist Review Questionnaire

\_\_\_\_\_  
Date

*Thank you for choosing Kittitas Valley Community Hospital.*