MADRAS
PHYSICAL THERAPY
ORTHOPEDIC & NEUROLOGIC REHABILITATION

PATIENT HISTORY QUESTIONNAIRE

CHART # _____

Date _____

Patient _____ Nickname _____
FIRST MIDDLE LAST

Your therapist will discuss your responses with you during the evaluation. Thank you for completing this information.

PERSONAL INFORMATION

I am currently: ☐Employed ☐ Employed with restrictions ☐ On medical leave ☐ Not employed

I currently: ☐ Live alone ☐ Live with caregiver ☐ Live with family members

Current living environment: ☐ Home/apartment ☐ Retirement home ☐ Assisted living

Do you smoke? ☐ Yes ☐ No Packs per day _____ Do you drink alcohol? ☐ Yes ☐ No Drinks per week _____

Do you exercise? ☐ Yes ☐ No Type _____ Times per week _____

Interests/hobbies/exercise _____

Will you have any problems attending therapy sessions? ☐ Yes ☐ No

GENERAL HEALTH

Medical conditions you currently have or have had in the past (check all that apply):

☐ Allergies ☐ Arthritis/Gout ☐ Blood Disorder ☐ Cancer ☐ Circulation/Vascular Problems ☐ Heart Disease

☐ Depression ☐ Diabetes ☐ Epilepsy/Seizures ☐ Fibromyalgia ☐ Head Injury ☐ Hearing Problems

☐ High Cholesterol/Lipids ☐ Recent Hospitalization ☐ Hypertension ☐ Infectious Disease ☐ Kidney Disease

☐ Liver Disease ☐ Lung Disease ☐ Migraines ☐ Multiple Sclerosis ☐ Osteoporosis ☐ Pacemaker

☐ Panic Attacks/Anxiety ☐ Parkinson's Disease ☐ Stomach Disease/Ulcer/Reflux ☐ Stroke/Paralysis

☐ Thyroid Disease ☐ Visual Problems ☐ Surgery – type(s) _____

If female, are you currently pregnant? ☐ Yes ☐ No

Are you taking any medications? ☐ Yes ☐ No If yes, please list _____

_____

Have you had any prior treatments for your current condition (check all that apply)?

☐ Hospitalization ☐ Bracing/Taping/Casting ☐ Physical Therapy ☐ Surgery ☐ TENS/Stimulation Unit

☐ Injections ☐ Chiropractics ☐ Acupuncture ☐ Other _____

Weight:_____ Height: _____