GENERAL HEALTH QUESTIONNAIRE

Name: _____ D.O.B: _____ Date: _____

It is important that you inform us of ALL medical/health conditions at your first appointment, and IMMEDIATELY inform us of any changes in your medical/health condition during your course of treatment. _____ (Yes, I understand)

Information about what brought you to Renew Manual PT:

What is/are the **main symptom(s)** that brought you to therapy today?

_____

_____

_____

Onset: When and did your symptom(s) begin (most recent flare-up)?

_____

☐ Sudden ☐ Gradual ☐ Due to an accident ☐ Due to an activity

Diagnostic Testing: Have any diagnostic tests been performed? Yes / No

☐ MRI: +/- ☐CT scan: +/- ☐Ultrasound: +/- ☐ X-ray: +/- Other: _____

Previous Treatment: Have you had any **non-PT** treatment for your symptom(s)? Yes / No

If "yes", please describe:_____

Have you had any **Physical Therapy** treatment for these symptom(s)? Y/ N

If "yes", please describe: _____

Easing Factors: Is there anything that makes your symptom(s) better?

_____

_____

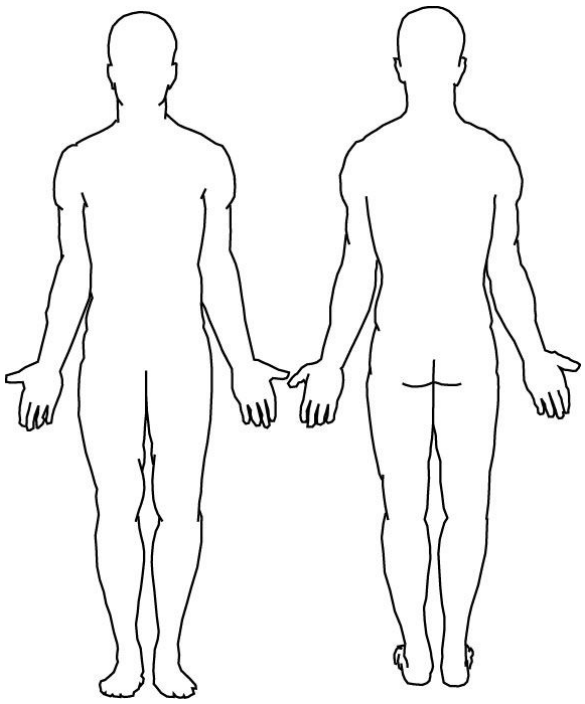
Self-Care: What are you currently doing for self-care of your symptom(s)?

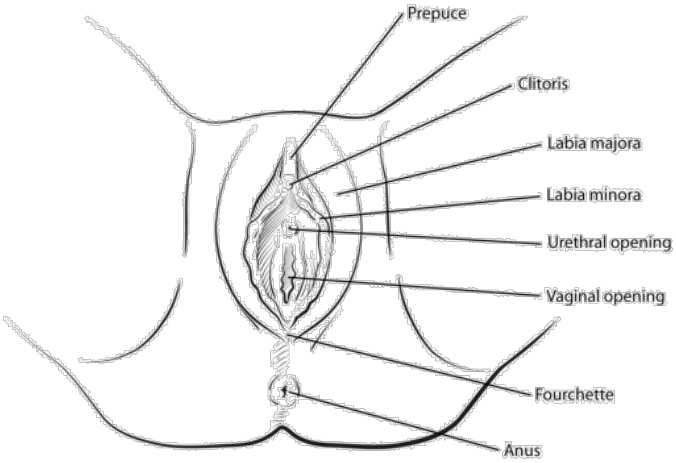
_____

Aggravating activities and limits you have to set on your normal activities?

ACTIVITY	TIME LIMITS?	MODIFICATIONS?	OTHER
Sitting			
Moving Sit to Stand			
Sleeping			
Moving Lying to Stand			
Working			
Computer Use			☐ Laptop ☐ Desktop
Phone Use			Use headset: Y/ N
Reading			Use Bifocals: Y/ N
Sports / Fitness			Type:
Driving			☐ Automatic ☐ Manual
Caring for Child / Pet			
Other			

PAIN RATING





Renew Manual
PHYSICAL THERAPY

GOALS for therapy:

_____

_____

Please provide the names of **ALL** other **Health Care Professionals** you are seeing:

NAME	REASON FOR CARE	LAST TREATMENT SESSION

"SUBSTANCE USE"	NEVER	RARELY	DAILY	CURRENT USE: HOW MUCH?	PAST USE:
Alcohol	[ ]	[ ]	[ ]	1 2 3 4 5 6+ drinks/day	Y / N
Tobacco	[ ]	[ ]	[ ]	1 2 3 4 5 6+ packs/day	Y / N
Recreational drugs	[ ]	[ ]	[ ]	Explain:	Y / N

Renew Manual
PHYSICAL THERAPY

PLEASE INDICATE IF YOU NOW HAVE, OR IN THE PAST HAD, ANY OF THE FOLLOWING (CHECK ALL THAT APPLY):

Nervous System
□ Head/Brain Injury
□ Stroke
□ TIA's
□ MS
□ Parkinson's
□ Peripheral Neuropathy
□ Epilepsy / Seizure Disorder
□ Other (list):

Respiratory System
□ Asthma
□ Emphysema or COPD
□ Pneumonia
□ Sinus Surgeries
□ Deviated Septum
□ Allergies (list)
□ Other (list):

Gynecological System
□ Sexually active
□ Yes □ No
□ Pain with intercourse
□ Inability to Orgasm
□ Lack of desire
□ Sexually transmitted disease

Pregnancy/Post-partum
□ Is there a possibility you could be pregnant now:
□ Yes □ No
□ Are you currently breastfeeding? □ Yes □ No
□ # pregnancies _____
□ # deliveries _____
□ Abortion: # _____ yr(s): ____
□ C-section: year(s): _____
□ Vaginal: year(s): _____
□ Episiotomy/tear: □ Yes □ No
□ Multiples
□ IVF
□ Hemorrhoids
□ Gestational Diabetes
□ Other issues:

Musculoskeletal & Connective Tissue Conditions
□ Spinal Stenosis
□ Spondylolisthesis
□ Herniated Disc-
□ Osteoporosis/ Osteopenia
□ Compression Fractures
□ Stress Fractures
□ Carpal Tunnel Syndrome
□ Arthritis
□ Lupus
□ Gout
□ Fibromyalgia
□ Migraine
□ Frequent Headaches
□ TMJ
□ Teeth Grinding
□ Other (list):

Urological System
□ Urinary Incontinence
□ Use of pads
□ 1-3 □ 4-6 □ > 6/day
□ Urinating Frequently
□ < 2 hrs □ < 1 hr
□ Urinating Urgency
□ Waking at night to urinate
□ 1-2/night
□ 3-4/night
□ > 4/night
□ Incomplete emptying
□ Repetitive UTI's/bladder infections: Most recent: _____
□ Frequent Loose Stools
□ Frequent Constipation
□ Fecal/Gas Incontinence
□ The need to strain

Cardiac / Circulation System
□ Heart Attach
□ Angina or Chest Pain
□ Irregular Heart Rhythm
□ Stents placed
□ Bypass Surgery
□ Heart Failure
□ Pacemaker or Defibrillator
□ Aneurism
□ Blood Clot
□ Bleeding/ Bruising tendency
□ Deep Vein Thrombosis-DVT
□ Neck, arm, jaw, or upper back pain with exertion
□ High blood pressure
□ High Cholesterol

Digestive Issues
□ Discomfort after meals
□ Hernia
□ Irritable Bowel Syndrome
□ Chron's Disease
□ Disordered Eating
□ Kidney Disease
□ Liver Disease

Endocrince & Immune System
□ AIDS
□ HIV positive
□ Hepatitis A B C (circle)
□ Diabetes Type 1 2 (circle)
□ Thyroid Imbalance
□ Low Blood Sugar
□ Cancer
Type(s):
Treatment: □ Radiation
□ Chemotherapy
□ Other

Renew Manual
PHYSICAL THERAPY

Traumas (please note years) □ Whiplash □ Fractures/ broken bones where:_____ □ Dislocations □ Ligament tear □ Bad sprains (list) □ Concussions (list) □ Motor Vehicle Accident (s) 1) When? _____ Driver □ Passenger □ Injured: Yes □ No □ If yes, what_____ 2) When? _____ Driver □ Passenger □ Injured: Yes □ No □ If yes, what_____ 3) When? _____ Driver □ Passenger □ Injured: Yes □ No If yes, what_____ □ Other (list):	**General Challenges** □ Falls Most recent: _____ □ > 2 in 1 year □ Shortness of breath □ on exertion □ lying flat □ Dizziness □ Balance Disturbance □ Anemia □ Memory loss □ Hearing loss □ Vision loss □ Sleep Apnea □ Insomnia □ Unusual Fatigue □ Alcoholism □ Substance Abuse □ current □ in recovery □ Clinical depression □ Mental or Emotional Disorder Please Explain:	**Other Illnesses, Accidents, & Hospitalizations:** (list if not included elsewhere)
Surgeries *Please list ALL surgical procedures with approximate dates **or** your age at the time (include metal & plastic implants, joint replacements, cosmetic & reconstructive surgeries, etc.)*	**Please list any other information regarding your medical and/or health history that you believe we should know:**	

Please Look over this Initial Questionnaire form carefully and be sure it is complete. Providing incorrect information can be dangerous to your health.

Please note: your therapist has the right to dismiss from treatment any patient who intentionally withholds pertinent medical and/or health information

Thank you for providing this information for us and please remember to immediately inform us of any changes in your medical and/or health condition during the course of treatment.

Signature _____ Date: _____