DENISE ALBERTO PHYSICAL THERAPY Inc.
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General Health History Questionnaire

Name: _____ Age: ___ DOB: _____ Sex: _____ Pronoun:_____

Referring Physician: _____

Emergency contact name: _____ Phone number: _____

Describe the problems for which you seek physical therapy treatment: _____
_____
_____

What are your goals for PT? _____
_____
_____

When did this problem begin and what was the incidence (what happened)? _____
_____
_____

Have you had this problem before and what treatment have you had in the past? _____
_____

What makes your problem better/worse? What helped?
_____
_____

Have you had surgeries in the past? If yes, please list and date.
_____
_____

Current list of Medications:
_____
_____

Any clinical tests within the past year?
_____
_____

Employment (Check all that apply)

☐ Full time ☐ Part time ☐ Homemaker ☐ Student ☐ Retired

Living Environment (Check all that apply)

☐ Stairs ☐ Uneven terrain ☐ Obstacles: _____

Assistive Devices (Check all that apply)

☐ Cane ☐ Walker ☐ Wheelchair ☐ Glasses ☐ Hearing aids

General Health History Questionnaire

General Health Status

Rate your perception of your health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

List any major life changes or illnesses in the past year: _____

_____

Social/Health Habits

☐ Smoking: Packs per day _____ ☐ Alcohol: Drinks per day _____

Sexual Relations: ☐ Pain with intercourse ☐ Abstinence ☐ Frequency _____

Family Relations: ☐ Difficulties ☐ Counseling ☐ Step family

Exercise beyond daily activities and chores. Describe frequency and duration (i.e. how many times a week for how many minutes): _____

_____

What do you wish you could be doing if not listed above? _____

_____

Family History (Check all that apply)

☐ Heart Disease
☐ Hypertension
☐ Stroke
☐ Psychological
☐ Arthritis
☐ Incontinence
☐ Alzheimer's
☐ Osteoporosis
☐ Diabetes
☐ Cancer
☐ Other:_____

Medical/Surgical History (Check all that apply)

☐ Arthritis
☐ Multiple Sclerosis
☐ Fracture/Osteoporosis
☐ Allergies
☐ Blood Disorders
☐ Diabetes
☐ Heart Condition
☐ Diabetes
☐ Head Injury
☐ Cancer
☐ Infectious Disease
☐ Kidney problems
☐ Asthma
☐ Lung problems
☐ Parkinson Disease
☐ Stomach Problems

☐ Low Blood Sugar ☐ Thyroid problems ☐ Vascular Disease

Within the last year have you had any of the following symptoms? (Check all that apply)

☐ Chest pain
☐ Shortness of breath
☐ Dizziness/blackouts
☐ Hoarseness
☐ Cough
☐ Loss of appetite
☐ Nausea/vomiting
☐ Unusual Weakness
☐ Rapid weight loss/gain
☐ Urinary problems
☐ Coordination Problems
☐ Blood sugar problems
☐ Bowel Problems
☐ Headaches
☐ Vision disturbances
☐ Difficulty walking
☐ Loss of Balance
☐ Pain at night
☐ Night sweats
☐ Fever
☐ Trouble swallowing
☐ Anxiety
☐ Depression
☐ COVID complications

Current Functional Status (Check all that apply and explain in the space provided)

☐ Difficulty with bed mobility ☐ Walking difficulty ☐ Loss of balance ☐ Transfer problems
☐ Self care difficulty ☐ Home management problems ☐ Difficulty with community activities

_____
_____

Anything we have missed or that you would like to tell us?

_____
_____
_____

MEN ONLY

Have you ever been diagnosed with prostate disease? ☐ Yes ☐ No
If yes, when_____
Do you have pain with intercourse?_____ Difficulty reaching orgasm?_____
Erection problems? _____
Leakage of urine or feces? (circle one) When does this happen?_____

WOMEN ONLY

Have you been diagnosed with any of the following? (Please check all that apply)

☐ Pelvic Inflammatory Disease
☐ Endometriosis
☐ Fibroids
☐ IC (Interstitial Cystitis)
☐ Complicated pregnancies/deliveries
☐ Currently pregnant

☐ Trouble with your periods: _____
☐ Other gynecological problems: _____
_____

OB history (number of vaginal deliveries, c-section, episiotomy, forceps) _____
_____
_____