DENISE ALBERTO PHYSICAL THERAPY Inc.
3425 S. Bascom Ave. Ste. F
Campbell, CA 95008
Phone: (408) 307-0901
Fax: (408) 384-5108

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 aides

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
☐ Other______________________________
☐ Arthritis
☐ Incontinence
☐ Alzheimer's
☐ Osteoporosis
☐ Diabetes
☐ Cancer

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
- ☐ Headaches
- ☐ 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) ___________________

____

____