



connect
PHYSICAL THERAPY
www.connectPT.org

1675 Whitehorse Mercerville Road
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P (609) 584-4770 F (609) 584-4880

201 Candlewood Commons
Howell, NJ 07731
P (732) 994-7755 F (732) 994-7757

**PHYSICAL THERAPY
NEW PATIENT
GENERAL HEALTH
QUESTIONNAIRE**

PATIENT INFORMATION

Name: _____ Age: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ E-mail: _____

Check here if you WOULD NOT like to receive email communications from Connect PT

Emergency Contact Name: _____ Relationship to You: _____

Phone: _____ Cell: _____ Work: _____

Employer: _____ Title: _____

Address: _____ City: _____ State: _____ Zip: _____

Work Phone: _____

Plan Subscriber: _____ Relationship to You: _____

Primary Ins. Plan: _____ Member ID #: _____

Secondary Ins. Plan: _____ Member ID #: _____

How did you hear about us? _____

Primary Physician: _____ Phone: _____

Referring Physician: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Your Signature

Date

Your Name (Please Print)



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PHYSICAL THERAPY NEW PATIENT GENERAL HEALTH QUESTIONNAIRE

Name: _____ Date of Birth: _____

1. What problem has brought you to physical therapy?

2. MEDICAL HISTORY: (Please check all conditions that apply to you)

- | | |
|---|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Discomfort in Chest |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> High Triglycerides |
| <input type="checkbox"/> Heart Surgery Date of surgery: _____ | <input type="checkbox"/> Ankle Swelling |

a. MEDICAL CONDITIONS

- | | | |
|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Labored Breath | <input type="checkbox"/> Cigarette Smoker |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Cancer | <input type="checkbox"/> History of Smoking |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Not Smoking now |

b. BONES & JOINTS

- Osteoporosis
- Scoliosis
- Fibromyalgia
- Arthritis
- Dropped Arches/Feet
- Joint Replacements Date of surgery: _____

c. PAIN

- No pain anywhere
- Feet
- Knees
- Hips
- Shoulders
- Abdomen
- Back/Neck
- Other



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Name: _____ Date of Birth: _____

2. MEDICAL HISTORY (CONTINUED): (Please check all conditions that apply to you)

d. FAMILY HISTORY

- Heart Attack
- Heart Disease
- High Blood Pressure
- Diabetes
- Other

e. SURGICAL HISTORY

- Back or Neck Date of Surgery: _____
- Abdominal Date of Surgery: _____
- R or L Knee Date of Surgery: _____
- Other joints Date of Surgery: _____

f. BOWEL/BLADDER

- Constipation
- Diarrhea
- Hemorrhoids

- Urinary Leakage
- Irritable Bowel Syndrome
- Bladder Surgery Date of Surgery: _____

g. BOWEL/BLADDER (FOR MEN ONLY)

- Prostate
- Prostate PSA Changes
- Difficulty with urine stream
- Pain with Urine
- Hernia
- Hernia Repair Date of Surgery: _____
- Other Surgery: _____ Date of Surgery: _____
- Scar Pain/Stuck Scar
- Pelvic Pain
- Pressure Feeling

h. OBGYN HISTORY (FOR WOMEN ONLY)

- | | |
|---|--|
| <input type="checkbox"/> Hysterectomy – Vaginal
Date of Surgery: _____ | <input type="checkbox"/> Laprascopic Surgery
Date of Surgery: _____ |
| <input type="checkbox"/> Hysterectomy – Abdominal
Date of Surgery: _____ | <input type="checkbox"/> Scar Pain/Stuck Scar |
| <input type="checkbox"/> Using Vaginal Cream | <input type="checkbox"/> Pregnant EDD: _____ |
| <input type="checkbox"/> Ovaries Removed
Date of Surgery: _____ | <input type="checkbox"/> “Falling out Feeling” |
| <input type="checkbox"/> C-Section
Date of Surgery: _____ | <input type="checkbox"/> Hormone Replacement |
| | <input type="checkbox"/> Pelvic Pain |
| | <input type="checkbox"/> Mentrual Pain |
| | <input type="checkbox"/> PMS |



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Name: _____ Date of Birth: _____

3. MEDICATIONS AND/OR VITAMINS YOU ARE NOW TAKING AND FOR WHAT REASON:

_____	DOSAGE: _____	REASON: _____
_____	DOSAGE: _____	REASON: _____
_____	DOSAGE: _____	REASON: _____

4. SOCIAL HISTORY:

Marital Status: _____

Educational Level (circle latest completed): High School College Graduate School

Hobbies: _____ # of family members living with you _____

What type of exercise are you doing now?

5. Check all the words that apply to how you feel these days:

___ Happy ___ Calm ___ Unmotivated ___ Stressed ___ Sad ___ Overwhelmed ___ Tired ___ Afraid ___ Lonely
___ Energetic ___ Lethargic ___ Content ___ Optimistic ___ Overworked ___ Weak Flabby Strong Un-rested Other:

6. I prefer to learn by:

- | | |
|---|--|
| <input type="checkbox"/> Listening (discussion, lecture, audio cassettes) | <input type="checkbox"/> Doing (demonstration, practicing skill) |
| <input type="checkbox"/> Seeing (reading, videos, displays, slides) | <input type="checkbox"/> Don't Know |

7. Is English your primary language? (circle that which applies) Yes No

If No, please specify: _____

8. What areas of your body are of concern to you? (circle that which applies)

Arms Legs Back Neck Belly Bottom

9. WHAT ARE YOUR GOALS FOR PHYSICAL THERAPY? (circle that which applies)

Lessen pain Increase muscle strength/ tone Improve bladder control Other: _____

10. Any other comments?

