connect
PHYSICAL THERAPY
www.connectPT.org

1675 Whitehorse Mercerville Road
Suite 101
Hamilton, NJ 08619
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 Today's Date

_____

Your Name (Please Print)

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Name: _____ Date of Birth: _____ Today's Date: _____

1. **What problem has brought you to physical therapy?**

_____

_____

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

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Pacemaker
- ☐ Heart Surgery Date of surgery:_____
- ☐ Discomfort in Chest
- ☐ Angina
- ☐ High Cholesterol
- ☐ High Triglycerides
- ☐ Ankle Swelling

a. MEDICAL CONDITIONS

- ☐ Diabetes
- ☐ Fainting Spells
- ☐ Shortness of Breath
- ☐ Dizziness
- ☐ Kidney Disease
- ☐ Thyroid Problems
- ☐ Difficulty Breathing
- ☐ Labored Breath
- ☐ Cancer
- ☐ Depression/Anxiety
- ☐ Visual Impairment
- ☐ Hearing Impairment
- ☐ Cigarette Smoker
- ☐ History of Smoking
- ☐ 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
- ☐ Pelvis
- ☐ Other

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Name: _____ Date of Birth: _____ Today's Date: _____

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)

- ☐ Hysterectomy – Vaginal
  Date of Surgery: _____
- ☐ Hysterectomy – Abdominal
  Date of Surgery: _____
- ☐ Using Vaginal Cream
- ☐ Ovaries Removed
  Date of Surgery: _____
- ☐ C-Section
  Date of Surgery: _____
- ☐ Laprascopic Surgery
  Date of Surgery: _____
- ☐ Scar Pain/Stuck Scar
- ☐ Pregnant EDD: _____
- ☐ "Falling out Feeling"
- ☐ Hormone Replacement
- ☐ Pelvic Pain
- ☐ Menstrual Pain
- ☐ PMS

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Name: _____ Date of Birth: _____ Today's Date: _____

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:

- ☐ Listening (discussion, lecture, audio cassettes)
- ☐ Seeing (reading, videos, displays, slides)
- ☐ Doing (demonstration, practicing skill)
- ☐ 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?

_____

_____

_____