connect PHYSICAL THERAPY
www.connectPT.org

1675 Whitehorse Mercerville Road
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PHYSICAL THERAPY NEW PATIENT GENERAL HEALTH QUESTIONNAIRE

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

Connect PT Resources

I CONSENT to the following forms of communication for appointment reminders and follow-up communication (please initial all that apply): email _____ phone/voicemail _____ text message _____

Preferred Email Address _____ Preferred Telephone Number _____

Do you give permission to Connect Physical Therapy to email you customized exercise programs and our quarterly newsletter which contains self-care tips, Connect PT events, articles and videos of interest to our patients?
_____YES _____NO

Health Information

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

_____

2. Medical History (Please check all conditions that apply to you.)

A. Medical Conditions

___ Angina
___ Ankle Swelling
___ Asthma
___ Cancer
___ Current Smoker
___ Depression/Anxiety
___ Diabetes
___ Difficulty Breathing
___ Other: _____
___ Discomfort in Chest
___ Dizziness
___ Fainting Spells
___ Heart Disease
___ Heart Surgery (list date below)
___ High Blood Pressure
___ High Cholesterol
___ High Triglycerides
___ History of Smoking
___ Kidney Disease
___ Labored Breath
___ Pacemaker
___ Shortness of Breath
___ Stroke
___ Thyroid Problems

B. **Allergies (Please list all allergies.)**

_____
_____
_____

C. Bones and Joints

___ Arthritis
___ Dropped Arches/Feet
___ Other: _____
___ Fibromyalgia
___ Joint Replacement
___ Fibromyalgia
___ Joint Replacement

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D. Pain (Please indicate areas with pain.)

___ No pain
___ Abdomen
___ Back/Neck
___ Elbow/wrist
___ Feet/Ankles
___ Hips
___ Knees
___ Pelvis
___ Shoulders

E. Family Medical History (Include parents, grandparents, siblings and children)

___ Family History Unknown
___ Cancer
___ Diabetes
___ Heart Attack
___ Heart Disease
___ High Blood Pressure
___ High Cholesterol
___ Kidney Disease
___ Osteoporosis
___ Respiratory Disease
___ Stroke/CVA
___ Other: _____

F. Surgical History

Type of Surgery_____ Date:_____
Type of Surgery_____ Date:_____
Type of Surgery_____ Date:_____
Type of Surgery_____ Date:_____
Type of Surgery_____ Date:_____

G. Bowel/Bladder

___ Bladder Surgery
___ Constipation
___ Diarrhea
___ Hemorrhoids
___ Irritable Bowel Syndrome
___ Urinary Leakage

H. Bowel/Bladder (Men Only)

___ Difficulty with Urine Stream
___ Hernia
___ Hernia Repair
___ Pain with Urination
___ Pelvic Pain
___ Pressure Feeling
___ Prostate
___ Prostate PSA Changes
___ Scar Pain/Stuck Scar

I. OB/GYN History (Women Only)

___ C-Section
___ "Falling Out Feeling"
___ Hormone Replacement
___ Hysterectomy
___ Laparoscopic Surgery
___ Menstrual Pain
___ Ovaries Removed
___ Pelvic Pain
___ PMS
___ Pregnant: EDD_____
___ Scar Pain/Stuck Scar
___ Using Vaginal Cream

J. Medications and/or vitamins you are currently taking:

_____ Dosage_____ Reason_____.
_____ Dosage_____ Reason_____.
_____ Dosage_____ Reason_____.
_____ Dosage_____ Reason_____.

K. Other conditions or comments:_____

_____

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

2. Social History

Marital Status: _____ Children _____

Educational Level: (Circle Highest Completed) High School College Graduate School

Hobbies: _____

Occupation:_____

What type of exercises are you doing now?_____

_____

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

___ Happy ___ Calm ___Sad ___Stressed ___ Optimistic ___ Overwhelmed

___ Tired ___ Afraid ___ Lethargic ___ Energetic ___ Content

___ Weak ___ Strong ___ Rested ___ Exhausted ___ Other:_____

4. I prefer to learn by: (Check all that apply)

___ Listening (discussion, lecture, audio cassettes) ___ Doing (demonstration, practicing skill)

___ Seeing (reading, videos, displays, slides) ___ Don't Know

5. **Is English your primary language? (Circle that which applies)** Yes No

If no, please specify your primary language: _____

6. What are your goals for Physical Therapy? (Check all that apply)

___ Decrease Pain ___ Improve Bladder Control ___ Improve Bowel Control

___ Improve Core Strength ___ Improve Sexual Function ___ Reduce Constipation

___ Other: _____

Date _____ Signature of Patient _____