

CASCADE SUMMIT PHYSICAL THERAPY

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Patient Questionnaire – Physical Therapy

1a. Name: _____
a. Last

_____ b. First _____ c. M.I.

b. DOB: _____

2. _____
a. Signature _____ b. Date _____

3. Age: _____ 4. Sex: _____

5. Are you right or left handed? _____

6. Date of Injury (If applicable) _____

7. Date of Last Doctor Visit: _____

Date of Next Doctor Visit: _____

8. Race:

Caucasian African-American
Native American Hispanic
Asian Other

9. Language:

English Understood
Need interpreter?
What language do you speak most often: _____

10. Employment:

Homemaker Full-time out of home
Student Full-time at home
Retired Part-time out of home
Unemployed Part-time at home
Occupation _____

11. Where do you live?

Private Home Long-Term Care Facility
Rented Room Private Apartment
Homeless Assisted Living
Hospice Other _____

12. Do you have help at home? _____

13. Does your home have:

Stairs, No Railing Elevator
Stairs, Railing Uneven terrain
Ramps Other _____

14. Do you use:

Cane Walker
Motorized wheelchair Manual Wheelchair
Crutches Other _____

15. General Health

a. Please rate your health:

Excellent Good Fair Poor

16. Have you had any major life changes during the past year?
(Such as a new baby, job change, death of a family member)

Yes No

17. Health habits

a. Do you exercise beyond normal daily activities/chores?

Yes No

If yes, please describe the exercise: _____

b. On average, how many days per week do you exercise or
do physical activity? _____

c. For how many minutes, on an average day? _____

d. Do you currently smoke tobacco? Yes No

e. If yes, do you smoke:

Cigarettes Number of packs per day _____

Cigars Number per day _____

Other Please describe _____

f. Have you smoked in the past? Yes No

If yes, year quit: _____

18. Family History

	Yes	No
a. Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
b. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
c. Stroke	<input type="checkbox"/>	<input type="checkbox"/>
d. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
e. Cancer	<input type="checkbox"/>	<input type="checkbox"/>
f. Other	_____	_____

19. Medications

a. Do you take any prescription medications? Yes No

If yes, please list: _____

b. Do you take any nonprescription medications? (Check all that apply.)

- | | | | |
|--------------------|--------------------------|--------------------|--------------------------|
| Advil/Aleve | <input type="checkbox"/> | Decongestants | <input type="checkbox"/> |
| Antacids | <input type="checkbox"/> | Herbal Supplements | <input type="checkbox"/> |
| Ibuprofen/Naproxen | <input type="checkbox"/> | Tylenol | <input type="checkbox"/> |
| Antihistamines | <input type="checkbox"/> | Other _____ | |
| Aspirin | <input type="checkbox"/> | _____ | |

20. Medical History

a. Please check if you have ever had:

- | | | | |
|-------------------------------------|--------------------------|----------------------------------|--------------------------|
| Allergies | <input type="checkbox"/> | Kidney Problems | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | Low Blood Sugar/
Hypoglycemia | <input type="checkbox"/> |
| Blood Disorders | <input type="checkbox"/> | Lung Problems | <input type="checkbox"/> |
| Broken Bones/Fractures | <input type="checkbox"/> | Multiple Sclerosis | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | Muscular Dystrophy | <input type="checkbox"/> |
| Circulation/Vascular
Problems | <input type="checkbox"/> | Osteoporosis | <input type="checkbox"/> |
| Depression | <input type="checkbox"/> | Parkinson's Disease | <input type="checkbox"/> |
| Developmental
or Growth Problems | <input type="checkbox"/> | Repeated Infections | <input type="checkbox"/> |
| Diabetes/High
Blood Sugar | <input type="checkbox"/> | Seizures/Epilepsy | <input type="checkbox"/> |
| Head Injury | <input type="checkbox"/> | Skin Diseases | <input type="checkbox"/> |
| Heart Problems | <input type="checkbox"/> | Stroke | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | Thyroid Problems | <input type="checkbox"/> |
| Infectious Disease | <input type="checkbox"/> | Ulcers/Stomach
Problems | <input type="checkbox"/> |
| | | Other _____ | |

21. Have you ever had surgery?

Yes No

If yes, please describe, and include dates:

_____	_____
_____	_____
_____	_____

22. Within the past year, have you had any of the following symptoms? (Check all that apply.)

- | | | | |
|------------------------|--------------------------|------------------------------|--------------------------|
| Bowel Problems | <input type="checkbox"/> | Joint Pain Or Swelling | <input type="checkbox"/> |
| Chest Pain | <input type="checkbox"/> | Loss Of Appetite | <input type="checkbox"/> |
| Coordination Problems | <input type="checkbox"/> | Loss Of Balance | <input type="checkbox"/> |
| Cough | <input type="checkbox"/> | Nausea/Vomiting | <input type="checkbox"/> |
| Difficulty Sleeping | <input type="checkbox"/> | Pain At Night | <input type="checkbox"/> |
| Difficulty Swallowing | <input type="checkbox"/> | Shortness Of Breath | <input type="checkbox"/> |
| Difficulty Walking | <input type="checkbox"/> | Urinary Problems | <input type="checkbox"/> |
| Dizziness Or Blackouts | <input type="checkbox"/> | Vision Problems | <input type="checkbox"/> |
| Fever/Chills/Sweats | <input type="checkbox"/> | Weakness In Arms And
Legs | <input type="checkbox"/> |
| Headaches | <input type="checkbox"/> | Weight Loss/Gain | <input type="checkbox"/> |
| Hearing Problems | <input type="checkbox"/> | Other _____ | |
| Heart Palpitations | <input type="checkbox"/> | _____ | |
| Hoarseness | <input type="checkbox"/> | _____ | |

23. Within the past year, have you had any of the following medical tests? (Check all that apply.)

- | | | | |
|-------------------------------|--------------------------|---|--------------------------|
| Angiogram | <input type="checkbox"/> | MRI | <input type="checkbox"/> |
| Arthroscopy | <input type="checkbox"/> | Myelogram | <input type="checkbox"/> |
| Biopsy | <input type="checkbox"/> | Nerve Conduction
Velocity | <input type="checkbox"/> |
| Blood Tests | <input type="checkbox"/> | Pap Smear | <input type="checkbox"/> |
| Bone Scan | <input type="checkbox"/> | Pulmonary Function
Test | <input type="checkbox"/> |
| Bronchoscopy | <input type="checkbox"/> | Spinal Tap | <input type="checkbox"/> |
| CT Scan | <input type="checkbox"/> | Stool Tests | <input type="checkbox"/> |
| Dopplerultrasound | <input type="checkbox"/> | Stress Test (e.g.,
treadmill, bicycle) | <input type="checkbox"/> |
| Echocardiogram | <input type="checkbox"/> | Urine Tests | <input type="checkbox"/> |
| EEG
(Electroencephalogram) | <input type="checkbox"/> | X-Rays | <input type="checkbox"/> |
| EKG (Electrocardiogram) | <input type="checkbox"/> | | |
| EMG (Electromyogram) | <input type="checkbox"/> | | |
| Mammogram | <input type="checkbox"/> | | |

24. History of Current Problem

a. When did the problem(s) begin (date)? _____

b. What happened? _____

c. Have you ever had the problems before? Yes No

If yes, what did you do for the problems? _____

d. Did the problems get better? Yes No

About how long did the problem(s) last? _____

e. What activities are you not able to do now that you could do before the problem(s)? (Please be as specific as you can; for instance, "Unable to reach over my head.") _____

f. Are you seeing anyone else for the problem(s)? (Check all that apply.)

- | | | | |
|---------------------------|--------------------------|------------------------|--------------------------|
| Acupuncturist | <input type="checkbox"/> | Occupational Therapist | <input type="checkbox"/> |
| Cardiologist | <input type="checkbox"/> | Orthopedist | <input type="checkbox"/> |
| Chiropractor | <input type="checkbox"/> | Osteopath | <input type="checkbox"/> |
| Dentist | <input type="checkbox"/> | Pediatrician | <input type="checkbox"/> |
| Family Practitioner | <input type="checkbox"/> | Podiatrist | <input type="checkbox"/> |
| Internist | <input type="checkbox"/> | Primary Care Physician | <input type="checkbox"/> |
| Massage Therapist | <input type="checkbox"/> | Rheumatologist | <input type="checkbox"/> |
| Neurologist | <input type="checkbox"/> | Other _____ | |
| Obstetrician/Gynecologist | <input type="checkbox"/> | _____ | |

25. Functional Loss Questionnaire (Mark Appropriate Box)

<i>Self-Care Activities</i>	<u>No Difficulty</u>	<u>With Difficulty/Pain</u>	<u>Cannot Perform</u>	<u>N/A</u>
Doing hair, combing, curling.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get wallet out of back pocket.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Putting coats, shirts on.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Putting pants, socks, shoes on.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuck shirt in.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women - fastening, unfastening bra.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Typing, zipping, snapping, buttoning.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Household Chores</i>				
Making the bed.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooking.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washing dishes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing laundry.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching into cupboards.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vacuuming.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweeping/Mopping floor.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mowing lawn.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting/Carrying.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weeding.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Raking.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watering yard.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Mobility</i>				
Walking.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going up/down stairs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting up off floor/ground.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting off toilet.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting in/out of bed.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting in/out of cars.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting in/out of bathtub.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving car.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Riding in car.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Exercise</i>				
Walking.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jogging.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swimming.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biking.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tennis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Golf.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gym.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

26. What are your personal goals for therapy?

_____	Relieve/reduce pain	_____	Return to sports, recreation, hobbies;
_____	Learn self-care techniques and prevention	_____	specify _____
_____	Resume/improve self-care activities,	_____	Improve sleep
	i.e. dressing, hair, etc.	_____	Improve posture
_____	Resume/improve household chores,	_____	Regain mobility/increase flexibility
	i.e. vacuuming, cleaning, etc.	_____	Regain strength/increase strength
_____	Resume/improve yard work, gardening, etc.	_____	Increase sitting tolerance
_____	Return to work activities	_____	Increase walking distance and speed
	specify _____		