MASSACHUSETTS GENERAL HOSPITAL
BOSTON, MASSACHUSETTS 02114
PHYSICAL THERAPY SERVICES

(LABEL)

HEALTH QUESTIONNAIRE

We would like to understand your health. Please complete this form as best you can. This is important information in a complete evaluation. This form is part of your medical record and is private. If you need help filling out this form, please ask at the front desk.

Today's Date: ____________________

Home Telephone: ____________________

Cellular Telephone: ____________________

Referring Physician: ____________________

Work Telephone: ____________________

Please answer the following questions:

1. Age: __________ Height: __________ Weight: __________
2. What injury or condition brings you here today? ____________________
3. When did this problem begin? ____________________
4. Have you received treatment for this problem? Yes No
5. Have you recently had any of the following tests: (If yes, check all that apply)

   ☐ X-rays ☐ Myelogram ☐ EMG/NCS ☐ Doppler Study
   ☐ CT Scan ☐ Bone Scan ☐ Blood Tests ☐ Pulmonary Functions Test
   ☐ MRI ☐ Stress Test ☐ EKG ☐ Other

   If yes please explain: ____________________

6. Have you had broken bones, surgery or been hospitalized in the past? (If yes, please list)

Reason:	Date:

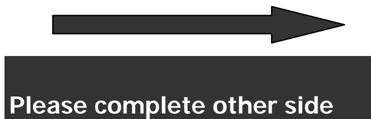
7. Are you pregnant or think you might be pregnant? Yes No
8. Do you have any allergies? Yes No

   Please list any allergies that you have (i.e.: medicines, latex, bee stings): ____________________

9. Do you smoke? ☐ Yes ☐ No If yes, how much? ____________________

   Would you like information on a program to stop smoking? Yes No

10. Have you experienced any slips and/or falls in the the past 6 months? Yes No



Please complete other side

HEALTH QUESTIONNAIRE

11. Do you take any medications? [ ] Yes [ ] No
    Please list any prescription or non-prescription drugs (i.e. herbal supplements) you are presently taking:

Medicine and reason for taking	Medicine and reason for taking

12.

Have you recently had:			For Therapist's Use Only:
Fever/Chills/Sweats	Yes	No	
Repeated Infections	Yes	No	
Recent Weight Gain/Loss	Yes	No	
Nausea/Vomiting	Yes	No	
Numbness/Tingling	Yes	No	
Weakness in your Arms/Legs	Yes	No	
Chest Pain/Heart Palpitations	Yes	No	
Pacemaker/Defibrillator	Yes	No	
Shortness of Breath/Cough	Yes	No	
Dizziness or Loss of Consciousness	Yes	No	
Chicken Pox	Yes	No	
Pelvic Inflammatory Disease	Yes	No	
Trouble with your period	Yes	No	
Bowel/Bladder Problems	Yes	No	

13.

Have you been diagnosed with:			For Therapist's Use Only:
High Blood Pressure/Heart Problems	Yes	No	
Lung Problems/Tuberculosis	Yes	No	
Infectious Diseases (ex. HIV, Hepatitis, MRSA)	Yes	No	
Cancer	Yes	No	
Kidney/ Liver Problems	Yes	No	
Arthritis/Osteoporosis	Yes	No	
Circulatory/Vascular Problems	Yes	No	
Head Injury	Yes	No	
Neurological Problems	Yes	No	
Thyroid Problems	Yes	No	
Seizures	Yes	No	
Visual Problems	Yes	No	
Hearing Problems	Yes	No	
Diabetes	Yes	No	

14. Do you:
    a. Have difficulty sleeping? Yes No
    b. Feel unsafe or afraid in your home? Yes No
    c. Avoid activities or people that remind you of your accident or injury? Yes No
    d. During the past month have you often been bothered by feeling down, depressed or hopeless? Yes No
    e. During the past month have you often been bothered by little interest or pleasure in doing things? Yes No

15. How do you learn best? [ ] Demonstration [ ] Visual [ ] Written [ ] Combination

16. What are your goals for physical therapy? ______________________________

Patient's Signature: ______________________________ Date: ______________

Therapist's Signature: ______________________________ Date: ______________