

**Ando & Aston Physical Wellness Therapy
New Patient Questionnaire**

Patient Name: _____ **Date:** _____

ONSET The date of my injury/accident OR onset of problem was *(date)*: _____

CAUSE My problem likely began because *(details)*: _____

TREATMENT Treatment of my problem to date has included/currently includes *(e.g. x-rays, surgery, PT)*: _____

YOUR GOALS *(what do you want PT to help you with? e.g. return to running)*: _____

I have been treated at Ando & Aston P.T. before *(details)*: _____

I have had X-rays, CAT scans, MRI etc. for this problem
(details): _____

MEDICATIONS *(Please mark the appropriate 'NO' lines, or if YES, provide details)*

NO

DETAILS

<input type="checkbox"/>	I am taking 'over the counter' anti-inflammatory, pain meds, or muscle relaxants	_____
<input type="checkbox"/>	I am taking <u>prescription</u> anti-inflammatory, pain meds, or muscle relaxants	_____
<input type="checkbox"/>	I am taking <u>other</u> medications	_____

PROBLEMS *(check and provide details)*

	MILD	MODERATE	SEVERE
Pain (area) _____	_____	_____	_____
Pain (area) _____	_____	_____	_____
Swelling	_____	_____	_____
Headaches	_____	_____	_____
Numbness/Abnormal sensation	_____	_____	_____
Other problem _____	_____	_____	_____
Loss of function (any type of normal activities)	_____	_____	_____
Loss of strength	_____	_____	_____
Loss of flexibility	_____	_____	_____
Loss of sleep	_____	_____	_____
Loss of balance (e.g. standing on 1 leg)	_____	_____	_____
Loss of bowel/bladder function	_____	_____	_____
Other loss _____	_____	_____	_____

SPECIAL QUESTIONS (Please mark the appropriate 'NO' lines, or if YES, provide details)

NO

DETAILS

- I am pregnant or think I might be pregnant _____
- I have a pacemaker, surgical hardware or other implanted device _____
- I have weight-bearing restrictions given to me by my doctor _____
- I have osteoporosis, osteopenia or history of fractures _____
- I have contact allergies to tape adhesives &/or latex, etc. _____
- I was told to limit physical activity due to a heart condition or onset of chest pain during activity _____
- I have other reasons why I should not do physical activity _____
- I have been diagnosed with any of the following: Hepatitis A, B &/or C; HIV/AIDS, sexually transmitted disease(s) or infections (i.e. herpes simplex, gonorrhea, HPV, etc.), vaginitis, pelvic inflammatory disease, yeast infection, trichomoniasis _____

REVIEW OF SYSTEMS (Please mark the appropriate 'NO' lines, or if YES, provide details)

NO

DETAILS

- General/Constitutional (e.g. fever or chills, poor general health, unexplained weight loss) _____
- Skin (e.g. rashes, new skin lesions, or a change in moles) _____
- Eyes (e.g. blurred vision, or change in visual acuity) _____
- Ears (e.g. ear pain, or difficulty hearing) _____
- Nose (e.g. nasal congestion, discharge, or bleeding) _____
- Mouth/Throat (e.g. sore throat, or difficulty swallowing) _____
- Neck (e.g. neck, jaw pain, headache, face numbness) _____
- Respiratory (e.g. shortness of breath, cough, wheezing, pain with breathing) _____
- Cardiovascular (e.g. high/low blood pressure, chest pain) _____
- Gastrointestinal (e.g. nausea, vomiting, diarrhea, constipation, abdominal pain, discolored stools, fecal incontinence) _____
- Genitourinary (e.g. problems initiating or controlling my bladder, or have urinary frequency) _____
- Musculoskeletal (e.g. joint or muscle pain, or back pain) _____
- Neurological (e.g. numbness, weakness, or tingling) _____
- Endocrine (e.g. heat or cold intolerance, weight loss or gain, increasing thirst) _____
- Hemato-Immunologic (e.g. bruise easily; bleeding, oral ulcerations or recurrent infections) _____
- Psychiatric (e.g. depression, anxiety, substance abuse or suicidal thoughts or attempts) _____

PAST MEDICAL HISTORY (Please mark the appropriate 'NO' lines, or if YES, provide details)

NO

DETAILS

- I have had serious infections (e.g. tuberculosis, pneumonia) _____
- I have had chronic illnesses (e.g. chronic sinusitis, arthritis, other autoimmune disorders, asthma, COPD, cancer in any area, _____

diabetes, epilepsy, dizziness, headaches, angina, heart disease, heart attack, hernia, stroke MS, Parkinson's, kidney, bladder, prostate, ulcers, GERDS, osteoporosis, osteopenia)

- _____ I have had the following general surgeries (e.g. appendectomy, gastrointestinal surgery, tumor removal, heart, kidney, and or lung transplant, CABG, pacemaker/pump or any other type of implant, carotid endarterectomy, laparoscopy, mastectomy, breast augmentation/reduction, cosmetic surgery, tubal ligation, ovarian cystectomy, hysterectomy, hernia repair, TURP)
- _____ I have had the following orthopedic surgeries (e.g. arthroscopy, repair, reconstruction, replacement, fusion, laminectomy, discectomy, ORIF (pins, plates, screws) to any area/joint)
- _____ I have had a history of falls or near falls
- _____ I use tobacco
- _____ Any OTHER medical history or procedures

OCCUPATIONAL HISTORY *(fill in all that apply)*

My occupation is _____

I am employed (or was employed at time of injury) at _____

My current job status is *(F/T, P/T, retired, disability etc.)* _____

If you have work limitations/restrictions what are they? _____

I currently attend school at _____ My grade/class is _____

My commute to work/school takes _____ minutes.

VITALS Height: _____ Weight: _____

Writing Hand (Circle) Left Right **Kicking Foot** (Circle) Left Right

INSTRUCTIONS

Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

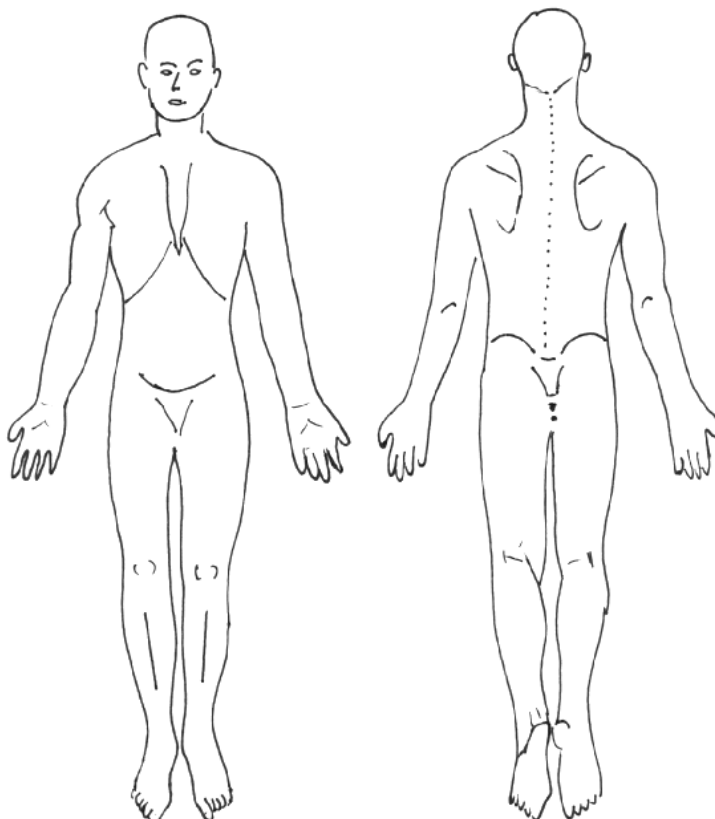
KEY

/// Stabbing

XXX Burning

000 Pins & Needles

=== Numbness



I verify the above information is complete and accurate, and have not omitted any medical conditions or history.

Patient or Responsible Party Signature

Date