

## Ando & Aston Physical 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, chiropractic)*: \_\_\_\_\_

**YOUR GOALS** *(what do you want physical therapy help you with? i.e. return to running)*: \_\_\_\_\_

I have been treated at Ando & Aston P.T. previously *(details)*: \_\_\_\_\_

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

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

**NO**

**DETAILS**

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

**PROBLEMS** *(check and provide details)*

	<b>MILD</b>	<b>MODERATE</b>	<b>SEVERE</b>
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 balance (e.g. standing on 1 leg) _____	_____	_____	_____
Loss of bowel/bladder function _____	_____	_____	_____
Other loss _____	_____	_____	_____

**SPECIAL QUESTIONS** *Please mark the appropriate 'NO' lines, or provide details*

**NO**

**DETAILS**

- \_\_\_ My pain is constant (24 hours a day, 7 days a week)
- \_\_\_ My pain travels (e.g. from neck to hand or from back to foot)
- \_\_\_ I am pregnant or think I might be pregnant
- \_\_\_ I have a metal implant or surgical hardware in my body
- \_\_\_ I have a pacemaker or other implanted device in my body
- \_\_\_ I have weight-bearing restrictions given to me by my doctor
- \_\_\_ I have osteoporosis or history of fractures
- \_\_\_ I have contact allergies to adhesives, latex, rubber etc.
- \_\_\_ I have a heart condition & was told not to do physical activity
- \_\_\_ I have pain in my chest when I do physical activity
- \_\_\_ I have had pain in my chest when not doing physical activity
- \_\_\_ I have other reasons why I should not do physical activity
- \_\_\_ I take vitamins
- \_\_\_ I am allergic to soy

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**TIMING** I have most of my symptoms (e.g. a.m versus p.m): \_\_\_\_\_

**AGGRAVATING FACTORS** The following actions, activities or positions aggravate my problem.

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**EASING FACTORS** The following actions, activities, positions, treatments or medications ease my problem.

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**REVIEW OF SYSTEMS** Please mark the appropriate 'NO' lines, or provide details including if this problem is NOT under care of a physician

**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 pain or swelling)
- \_\_\_ Respiratory (e.g. shortness of breath, cough, wheezing)
- \_\_\_ Cardiovascular (e.g. high/low blood pressure, chest pain)

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**NO**

**DETAILS**

- \_\_\_ Gastrointestinal (e.g. nausea, vomiting, diarrhea, constipation, abdominal pain or discolored stools) \_\_\_\_\_
- \_\_\_ 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 provide detail)

**NO**

**DETAILS**

- \_\_\_ I have had serious infections (e.g. tuberculosis, pneumonia) \_\_\_\_\_
- \_\_\_ I have had chronic illnesses (e.g. chronic sinusitis, rheumatoid arthritis, osteoarthritis, asthma, cancer in any area, diabetes, epilepsy, dizziness, headaches, heart disease, heart attack, hernia, multiple sclerosis, Parkinson's, osteoporosis, stroke) \_\_\_\_\_
- \_\_\_ I have had the following general surgeries (e.g. appendectomy, gastrointestinal surgery, tumor removal, heart, kidney, and or lung transplant, CABG, pacemaker 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, diskectomy, ORIF (pins, plates, screws) to any area/joint) \_\_\_\_\_
- \_\_\_ I have had a history of falls or near falls \_\_\_\_\_
- \_\_\_ I use tobacco \_\_\_\_\_
- \_\_\_ I have a history of total Cholesterol greater than 240 mg/dl \_\_\_\_\_
- \_\_\_ Family history of coronary heart disease or other atherosclerotic disease in parents or siblings before age 55 \_\_\_\_\_

**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.

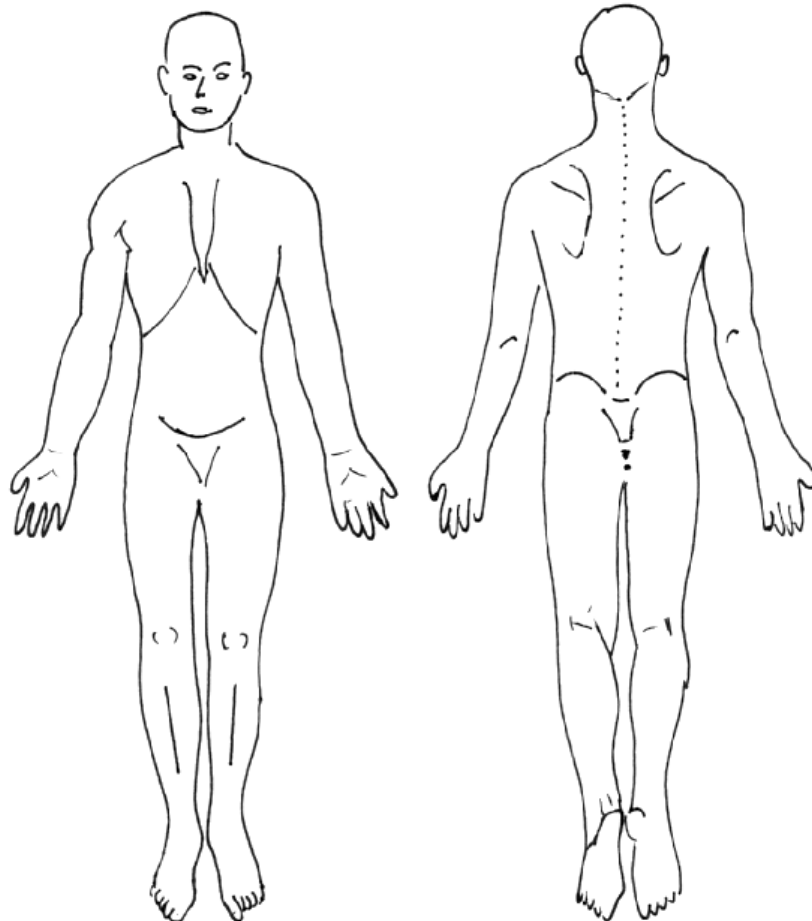
### KEY

/// Stabbing

XXX Burning

000 Pins & Needles

=== Numbness



I verify the above information is complete and accurate.

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Patient or Guardian

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Date