HPTNYC
HOME PHYSICAL THERAPY

PHYSICAL THERAPY QUESTIONNAIRE

Date: _____

Name: _____ Height_____Weight _____ Age _____

Occupation: _____

Living environment: _____ **Do you live alone?** Yes No

If no, who do you live with:_____

Does your home have:
____Stairs, no railing ____Stairs, w/railing ____Ramps
____Elevator
____Uneven Terrain ____Other: _____

General Health

Do you use:
____Cane
____Walker or rollator ____Manual Wheelchair ____Motorized wheelchair
____Other_____

Please rate your health:

____Excellent ____Good ____Fair ____Poor

Health Habits

Do you exercise regularly? _____ Yes _____No

If yes, how often and what type of activities?
_____
_____

Family History

(Indicate whether mother, father, brother/sister, aunt/uncle, or grandmother/grandfather had any of the following disorders and provide age of onset if known)

Heart disease: _____

Hypertension: _____

Stroke: _____

Diabetes: _____

Cancer:_____

Other: _____

Medications:
Do you take any prescription medications? ___ Yes ___ No

HPTNYC
HOME PHYSICAL THERAPY

If yes, please list:
_____
_____
_____
_____

Past Medical History:

Please check if you have ever had: ____ High blood pressure
____ Arthritis
____ Blood disorders
____ Broken bones
____ Cancer
____ Vascular problem
____Depression
____ Infectious disease (such as tuberculosis, hepatitis)
____ Kidney problems
____ Low blood sugar
____ Lung problems ____ Multiple sclerosis ____ Osteoporosis
____ Developmental problems ____ Diabetes
____ Stroke
____ Thyroid problems
____ Parkinson's diseases
____ Seizures/epilepsy
____ Heart problems

Current Limitation (Check all that apply)

___ Difficulty with bed mobility
___Difficulty with transfers (such as moving from bed to chair, from bed to commode)
___ Difficulty walking on leve lsurface
___ onstairs
___onramps
___ on uneven terrain
___Difficulty with self-care (such as bathing, dressing, eating, toileting)
___Difficulty with household chores, shopping, driving ___ Difficulty with community and work activities/integration
___ Difficulty work/school
___ Difficulty recreation or play activity

History of Current Problem(s)

When did the problem(s) begin? ____/____/____ What occurred?
_____
_____ _____

Have you ever had the problem(s) before? ___ Yes ____ No

What did you do for the problem(s)?
_____
_____

Did the problem(s) get better? ____ Yes ____ No

About how long did the problem last? _____

HPTNYC
HOME PHYSICAL THERAPY

What makes the problem better / worse _____
_____

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”)
_____
_____
_____

Rate the level of your pain on the following scale. Atpresent:0 1 2 3 4 5 6 7 8 9 10

At best: 0 1 2 3 4 5 6 7 8 9 10

At worst: 0 1 2 3 4 5 6 7 8 9 10 (no pain) (moderate) (extreme)

Please draw pain on body chart

Pain description (please circle): Sharp Dull Burning Aching Tingling Numbness

+ = numbess

0 = pins/needles