



## Orthopedic and TMJ Physical Therapy Center

### Confidential Health Questionnaire

### General Orthopedic

Name: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

Date: \_\_\_\_\_

Occupation: \_\_\_\_\_

**General Health Questions**

1. Have you ever had any of the following conditions or problems? Be descriptive when appropriate.

- |  |  |   |
|--|--|---|
| <input type="radio"/> Anemia<br><input type="radio"/> Arthritis<br><input type="radio"/> Asthma<br><input type="radio"/> Cataracts<br><input type="radio"/> Cancer<br><input type="radio"/> Chest Pains<br><input type="radio"/> Circulatory problems<br><input type="radio"/> Constipation/Impaction<br><input type="radio"/> Convulsions<br><input type="radio"/> Diabetes<br><input type="radio"/> Digestive problems<br><input type="radio"/> Dizziness<br><input type="radio"/> Eliminary problems<br><input type="radio"/> Falls<br><input type="radio"/> Fractures<br><input type="radio"/> Head aches<br><input type="radio"/> Head Injuries | <input type="radio"/> Heart condition<br><input type="radio"/> Hemophilia<br><input type="radio"/> Hemorrhoids<br><input type="radio"/> High/low blood pressure<br><input type="radio"/> HIV, AIDS<br><input type="radio"/> Irritable Bowel<br><input type="radio"/> Kidney/Bladder Stones<br><input type="radio"/> Migraines<br><input type="radio"/> Mitral valve prolapse<br><input type="radio"/> Multiple Sclerosis<br><input type="radio"/> Osteoporosis<br><input type="radio"/> Osteomyelitis<br><input type="radio"/> Pacemaker<br><input type="radio"/> Parkinson's Disease<br><input type="radio"/> Polyps<br><input type="radio"/> Phlebitis<br><input type="radio"/> Pregnancy Trauma | <input type="radio"/> Renal Diesase<br><input type="radio"/> Respiratory problems<br><input type="radio"/> Seizures<br><input type="radio"/> Skin Conditions<br><input type="radio"/> Thyroid problems<br><input type="radio"/> Vascular Disease<br><input type="radio"/> Musculoskeletal <ul style="list-style-type: none"> <li><input type="radio"/> TMJ    <input type="radio"/> Shoulders</li> <li><input type="radio"/> Neck    <input type="radio"/> Hips</li> <li><input type="radio"/> Back    <input type="radio"/> Knees</li> <li><input type="radio"/> Feet</li> </ul> |
|--|--|---|

Other \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. When was your last Medical exam?    Within last month    Within last 6 months    More than 6 mo.

3. Do you Smoke?    Yes    No

4. Education    High School     College     Graduate     Professional Training

5. Are you currently under the care of a physician/chiropractor/therapist/acupuncturist, counselor... etc, ?  
 Provider's Name & Specialty

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

6. Please list all medications you are currently taking (prescription and over the counter)?

Name & Dosage	Reason for taking
_____	_____
_____	_____
_____	_____

7. Do you drink alcohol (if so list # per week)?  No \_\_\_\_\_ Beer. \_\_\_\_\_ Wine. \_\_\_\_\_ Spirits.

8. Indicate what amount you drink of the following in a typical day. \_\_\_\_\_ Water (8oz.) \_\_\_\_\_ Juice (8oz.)  
\_\_\_\_\_ Coffee (cups) \_\_\_\_\_ Tea (cups) \_\_\_\_\_ Soda (8oz.)

9. Have you ever been treated for any of the following:

- Anxiety
- Depression
- Drug Addiction
- Nervous Problems
- Constipation
- Heart Burn

10. Do you experience:

- Numbness/tingling/weakness in anywhere in your body
- Urinary leaking or urge with exercise, laughing, coughing, or on the way to the bathroom
- Pain with urination or sexual activity
- Clicking, popping or pain in your jaw

11. Please list any past injuries, accidents and surgeries: (include dates if possible): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. Have you ever seen a physical therapist before?  Yes  No

13. Please list exercise, sports, hobbies or musical instruments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. Please describe your diet. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Please list food, medication or other allergies: \_\_\_\_\_  
\_\_\_\_\_

15. Please Describe your sleeping habits (Snoring, # of hours, position, # of pillows) . \_\_\_\_\_  
\_\_\_\_\_

16. How did you hear about our clinic? \_\_\_\_\_

17. Please describe in our own words your pain pattern or concerns  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. **Life Impairment:** What are your feelings about your problem on a scale of 1 to 10?  
No Impairment 0 1 2 3 4 5 6 7 8 9 10 Severe Impairment