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SSOR
Specialists in Sports and Orthopedic Rehabilitation

Patient Name: _____

MR #: _____

Patient History Questionnaire

Your therapist will discuss your personal information and goals for therapy with you during the evaluation. Thank you for completing this information.

PERSONAL INFORMATION

I am currently: ☐ Employed ☐ Employed with restrictions ☐ On medical leave ☐ Not employed - # Hours/week _____

Interests/hobbies are: _____

Is there anyone who can assist you with doing home exercises or activities, if needed? ☐ Yes ☐ No

Will you have any problems attending therapy sessions? ☐ No ☐ Yes If yes, please describe:

_____

General Health

1. Activity level: ☐ Low ☐ Medium ☐ High

2. Are you having trouble sleeping? ☐ Yes ☐ No
   Normal hours of sleep _____hours.
   Current hours of sleep _____hours

3. Are you experiencing any of the following:

☐ Apprehension	☐ Avoiding/uncomfortable with people
☐ Crying episodes	☐ Low energy or frequent fatigue
☐ Less talkative than usual	☐ Decreased sexual interest
☐ Flushing	☐ Weight loss (10 lbs or more)
☐ Increased perspiration	
☐ Increased negative feelings about injury or future	

4. Medical conditions you have or have had. (Check all that apply.)

☐ Arthritis	☐ Stroke
☐ Cancer: ☐ In remission	☐ Stomach Disorders *(ulcers, etc.)*
☐ Diabetes	☐ Anxiety
☐ Heart Disease	☐ Depression
☐ High Blood Pressure	☐ Panic Attacks
☐ Lung Disease	☐ Gland Problems *(thyroid)*
☐ Pacemaker	☐ Head injury or trauma
☐ Visual problems	☐ Asthma
☐ Hearing problems	☐ Other:

_____

_____

5. Uncontrolled leakage of urine/loss of bowel control? ☐ Yes ☐ No

6. Significant dental work? (ie braces, extractions, crowns)
   ☐ Yes ☐ No If yes, please specify: _____

7. Is there any chance you might be pregnant? ☐ Yes ☐ No

8. Do you smoke? ☐ Yes ☐ No If yes, packs per day: _____

9. Do you drink alcohol? ☐ Yes ☐ No If yes, frequency: _____

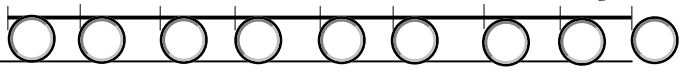
10. Are you on a special diet? ☐ Yes ☐ No
    Specify _____

11. Are you taking any medications including over the counter, prescription, herbs, supplements, vitamins? ☐ Yes ☐ No
    If yes, please list:
    _____
    _____
    _____

12. Do you have any allergies (eg. adhesives, latex, cortizone)?
    ☐ Yes ☐ No If yes, please list with any reactions/treatments:
    _____
    _____
    _____
    _____
    _____

13. What is the level of your **pain?**

No Pain — *Worst Pain Imaginable*



PERSONAL GOALS FOR THERAPY

14. What do you **WANT TO** achieve from having therapy? Check all that apply:

☐ Improve home activities	☐ Improve mobility/walking activities	☐ Decrease or eliminate pain/discomfort
☐ Improve leisure/sports activities	☐ Improve ability to communicate	☐ Return to work: ☐ Current job ☐ Other job
☐ Improve self care activities	☐ Improve swallowing	☐ Other_____

15. Please include any additional information you feel would help us provide your care (ie. what you think would help, any apprehensions about treatment, spiritual or cultural needs).

_____

_____

_____

To the best of my knowledge, the above information is complete and factual.

_____ _____

Patient Signature ***Date***