HARRISON PHYSICAL THERAPY, LLC.
HEALTH HISTORY QUESTIONNAIRE OUTPATIENT

Date:

Name:		
Cell Number:		**Email:**
Address:		
DOB:		
Primary Physician:	**Phone:**	**Fax:**
Primary reason/problem seeking PT:		

General Health

1. **Rate you current Health: Poor Fair Good Excellent**
2. **Do you exercise on a regular basis? Yes No**
3. **Do you smoke currently or in the past? Yes No**
4. **How many days per week do you drink alcohol on average?**
5. **How many caffeinated beverages do you drink per day?**

Please place a checkmark beside any of the following that apply to you below:

6. Frequent bathroom visits.
7. Having to frequently start and stop when you're trying to pee.
8. Straining or pushing to pass a bowel movement.
9. Having to change positions on the toilet or use your hand to eliminate stool.
10. Constipation
11. Leaking stool
12. Leaking urine
13. Painful Urination.
14. Unexplained lower back pain
15. Ongoing pain in your pelvic region, genitals or rectum — with or without a bowel movement

Personal Medical History:

Current Problem Description: (**Primary concern and how function is impacted**)

Surgical History:

Surgery Type	Date	Current Functional Limitations/Restrictions as a Result of Surgery

Medication Use: Including over the counter medications (Tylenol/Aspirin)

Medication	Dosage	Frequency	Purpose

Do you take any natural preparations, supplements or vitamins?
YES NO

Natural Preparation/Supplement	Dosage	Frequency	Purpose

Patient Goals For Physical Therapy: **(Circle all that apply)**

Reduce Pain/Swelling
Increase Mobility of Joint **Improved Walking** **Improved Transfer**
Learn a Skill **Strengthen** **Improve Activity/Function**