**NEW DIMENSIONS PHYSICAL THERAPY**
**PATIENT MEDICAL HISTORY**
**Kern-Steiner, Inc.**

**Patient Name:** _____ **Date:** _____

**Past Medical History:** Place a check mark next to all medical conditions you have had:

| | | |
|---|---|---|
| Alcoholism | Dizziness or Vertigo | Lung Disease |
| Anemia | Glaucoma | Open Sores or Wounds |
| Arthritis | Heart Disease or Condition | Pacemaker |
| Blood Thinners | Hepatitis | Seizures |
| Cancer | High Blood Pressure | Stroke |
| Chest Pains | HIV or AIDS | Thyroid Disease |
| Diabetes | Joint Replacement | Tuberculosis |
| Diverticulitis | Kidney or Bladder Infection | Ulcers |

Other Problems:_____

**Is there a history in your blood relatives of (check all that apply):**

Abnormal Bleeding Arthritis Cancer Heart Disease Lupus Muscle Disease

Rheumatoid Arthritis Other:_____

**Surgeries & Hospitalizations:**

_____ Year:_____
_____ Year:_____
_____ Year:_____
_____ Year:_____

**Injuries, Fractures, & Dislocations:**

_____ Year:_____
_____ Year:_____
_____ Year:_____
_____ Year:_____

**Have you had problems with anesthesia, infection, bleeding, or other surgical complications?**

No Yes (please explain):_____

_____

| **Current Medications:** | **Dose:** | **Date Started:** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**One of our specialties is treating pelvic floor dysfunction. To determine if you could benefit from this approach please consider the following:**

Have you fallen on your tail bone? Y N

Do you have pain or burning during urination? Y N

Do you urinate more than 7 times in one day? Y N

Do you wake up at night and need to urinate? Y N

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Do you have frequent urinary tract infections? Y N

Do you have pain with sexual intercourse? Y N

Do you have pain with bowl movements? Y N

How often do you move your bowels _____ per day/week?

Do you lose urine when you: Cough/sneeze/laugh Y N

Lift/exercise/dance/jump Y N

On the way to the bathroom Y N

Hear water running Y N

Is it possible you snore at night? Y N

Is there a possibility you have sleep apnea? Y N

**Description of Your Normal Job Activities:** How many hours are in your average workday? _____

What is the maximum time you spend doing each activity in one day at work:

Sitting:_____ Standing:_____ Walking:_____ Driving:_____ Lifting:_____

If lifting, what is the average weight lifted at one time: _____ How many times per hour? _____

**Lifestyle Habits:** Tobacco: _____ cigs/day Caffeine: _____ cups/day Sleep: _____ hours/day

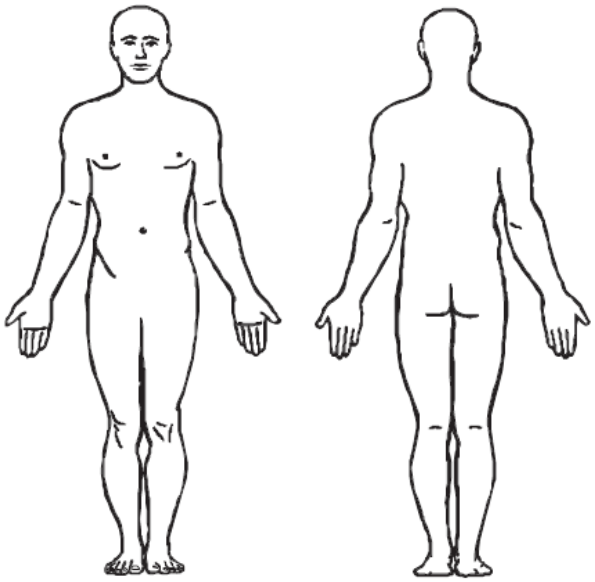
If you currently exercise, check the appropriate type and indicate the frequency.

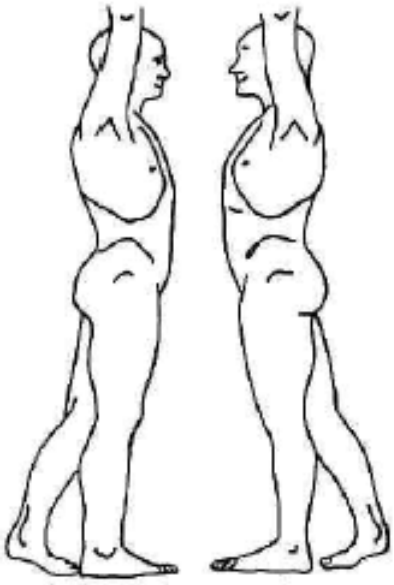
Cardiovascular: _____ hrs/week Weight Lifting: _____ x/week Stretching: _____ x/week

Other: _____ x or hrs/week Other: _____ x or hrs/week

**Regarding Your Present Injury and Health Issues:** Use the following symbols to show the area on the drawings where you have symptoms.

>>> **ACHE** □□□ **NUMBNESS** ○○○ **PINS & NEEDLES** XXX **BURNING** /// **STABBING**





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**Impact of Present Condition:**
Please list the number which best describes how much your activities, relationships, or feelings have been affected by your condition/injury:

1 = Not at all 2 = Somewhat 3 = Moderately 4 = Quite a bit

1. Ability to do household chores (cooking, housecleaning, laundry)? _____
2. Ability to do physical activities (walking, swimming, running, etc.)? _____
3. Entertainment activities such as going to a movie or concert? _____
4. Ability to travel by car/bus more than 30 minutes away? _____
5. Emotional health (nervousness, depression, anger, etc.)? _____
6. Feeling frustrated? _____

**Quality of Life**
If you were to spend the rest of your life with your symptoms just the way they have been during the last 2 weeks, circle the description that best represents how you would feel about that?

0 Delighted 1 Pleased 2 Mostly satisfied 3 Mixed 4 Mostly dissatisfied 5 Unhappy 6 Terrible

**Activity Tolerance:** How long can you tolerate the following activities in minutes/hours?

| | Onset of Pain | Symptoms Interrupt Activity |
|---|---|---|
| Sitting on a hard surface | ____min/hours | ____min/hours |
| Sitting on a soft surface | ____min/hours | ____min/hours |
| Driving | ____min/hours | ____min/hours |
| Desk/computer work | ____min/hours | ____min/hours |
| Exercise | ____min/hours | ____min/hours |
| Household chores | ____min/hours | ____min/hours |
| Yard work | ____min/hours | ____min/hours |
| Sleeping | ____min/hours | ____min/hours |

**Goals:** What personal goals would you like to reach with physical therapy, both short and long term?
1._____

2._____

3._____

**I have read and understand this questionnaire and it is accurate and complete to the best of my knowledge. Any question I was unclear about was explained to my complete satisfaction.**

_____ _____
Patient Signature Date

_____ _____
Legal Guardian Signature (for minor patients) Date

Thank you very much for taking the time to complete this questionnaire.