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
Anemia
Arthritis
Blood Thinners
Cancer
Chest Pains
Diabetes
Diverticulitis

Dizziness or Vertigo
Glaucoma
Heart Disease or Condition
Hepatitis
High Blood Pressure
HIV or AIDS
Joint Replacement
Kidney or Bladder Infection

Lung Disease
Open Sores or Wounds
Pacemaker
Seizures
Stroke
Thyroid Disease
Tuberculosis
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, Factures, & 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

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

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

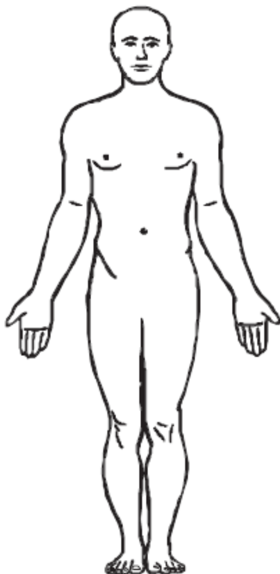
If you currently exercise, check the appropriate type and indicate the frequency.

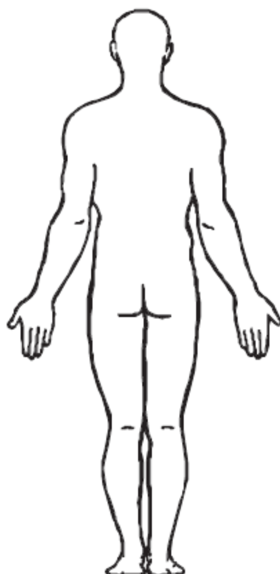
Cardiovascular: ______ hrs/week Weight Lifting: ______ x/week Stretching: ______ x/week

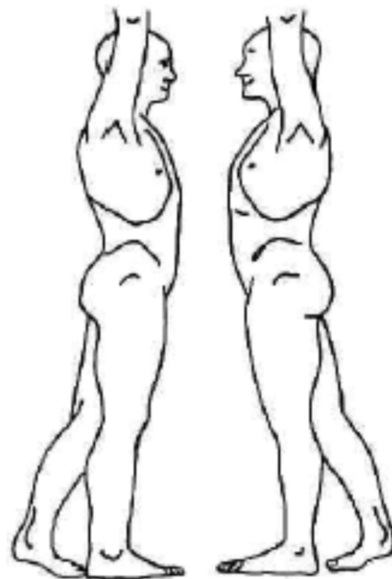
Other: ______________________ x or hrs/week Other: ______________________ x or hrs/week

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**







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

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.