Sandhills Sports Performance
Physical Therapy Health Questionnaire

Thank you for choosing SHSP for your rehabilitation health care. Please take a few moments to answer the following health related questions to better assist your therapist at meeting your specific needs or concerns.

Name:_____ DOB:_____

Who referred you to us or how did you hear about us?_____

Please list anyone involved in your care or payment for your care with whom we may share your medical information with? _____

Tell us a little bit about what your problem/pain/limitations are: _____

_____

What are your specific goals? _____

_____

MEDICAL HISTORY

Height _____ Weight _____

Please circle any of the following health problems that pertain to you

AIDS/HIV
Allergies
Anemia
Anxiety Disorder
Arthritis
Artificial Joints
Asthma
Bleeding Disorder
COPD
Cancer
Carpel Tunnel
Chronic ear infections
Depression
Diabetes
Difficulty swallowing
Emphysema
Epilepsy/Seizures
Fibromyalgia
Gout
Head Injury/Concussion
Head Trauma/Injury
Headaches/Migraines
Heart Disease
Hernia
High Cholesterol
Hyperlipidemia
Hypertension
Hyperthyroidism
Hypothyroidism
Kidney Disease
Lung Disease
Lyme Disease
Meniere's disease
Multiple Sclerosis
Muscle, Joint, or Bone Problems
Neck Injury
Neurological Disorder
Neuropathy
Organ Transplant
Osteoporosis
Pacemaker
Peripheral Vascular Disease
Polio
Pulmonary Embolism
Reflux/GERD
Rheumatoid Arthritis
Seizures/Epilepsy
Serious Illness or Injuries
Stroke
Thyroid Disease
Thyroid Problems
Heart Arrhythmia
Sports induced asthma

Previous Surgeries? (List Procedures/dates) _____

_____

_____

_____

Have you had braces or jaw surgery? _____

Do you wear glasses or contacts? _____

Have you had any eye surgery?_____If yes, please explain _____

Prior orthopedic (bones, joints, muscle) injuries or pain?_____

_____

Any headaches, tinnitus (ringing in the ear), TMJ (jaw pain), anxiety, or depression? (Circle any that apply)

Pregnancies? _____ Type of Delivery?_____

Do you have challenges with sleep? YES NO

Do you have digestive issues? YES NO

List any medications you are allergic to? _____

Please write any medication you are currently taking (including dosage and how often taken): _____

_____

_____

_____

Please list any health problems or conditions that any of your immediate family have or had (Mother, Father, Sister, Brother, and Maternal Grandparents)

_____

_____

_____

SOCIAL HISTORY

Exercise Level? None Occasional Moderate Heavy

Hand Dominance? Right Left Bilateral

Marital Status? Single Married Divorced Separated Widowed Domestic Partner

Occupation? _____

Smoking Status? Never Smoker Former Smoker Current Every Day Smoker Current Some Day Smoker

How much per day? _____ How many years of use? _____

Auto related injury? YES NO Work Related Injury? YES NO

Able to care for self? YES NO

What do you like to do for fun? _____

_____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM!