# JORGENSEN PHYSICAL THERAPY GROUP

## Client Health Questionnaire

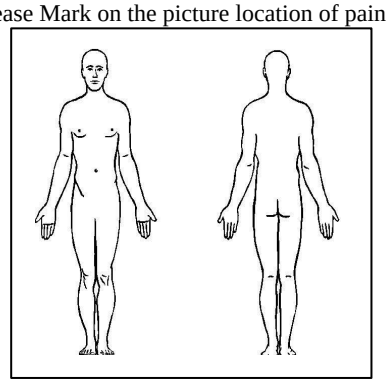
Name_____Age_____Date_____/_____/_____

Please describe your current complaint or limitation: _____
Please describe how your problem began:_____
Please tell us how long ago your condition started:_____
List tests or other interventions for this condition that you have had:_____
Please indicate the daily activities that you cannot perform:_____
Please indicate your level of functioning prior to the onset of this condition:_____
Please inform us of any environmental or living conditions that may have difficulties with:_____
Did you have surgery? ___No ___Yes Date___/___/___Procedure:_____

Please describe the nature of your symptoms (check all that apply):

- ☐ Vertigo
- ☐ Lightheaded
- ☐ Feeling "off"
- ☐ Ear Pressure/Pain
- ☐ Motion intolerant
- ☐ Head Injury/Concussion
- ☐ Sharp Pain
- ☐ Dull Ache
- ☐ Numbness
- ☐ Shooting
- ☐ Burning
- ☐ Tingling
- ☐ Constant (76%-100%)
- ☐ Frequent (51%-75%)
- ☐ Occasional (26%-50%)
- ☐ Intermittent (25%-or less)

Please Mark on the picture location of pain



Level of symptoms at rest from 0 (None) to 10 (Unbearable)_____
Level of symptoms with activity from 0 (None) to 10 (Unbearable)_____
Since this condition began your symptoms have ☐decreased ☐ not changed ☐ increased
Your symptoms are worse in: ☐ morning ☐afternoon ☐night ☐increased during the day ☐same all day
Activities or positions that increase symptoms:_____
Activities or positions that decrease symptoms:_____
Occupation _____ Has your work status changed because of this condition? ☐YES ☐NO.

If you have ever had a listed condition in the past, please check it in the PAST column, if your presently troubled by a particular condition, check it in the PRESENT column. The information you provide concerning past and present conditions and diseases assist your therapist in more thoroughly understanding your state of health.

| Past | Present | |
|---|---|---|
| ___ | ___ | High Blood Pressure |
| ___ | ___ | Angina |
| ___ | ___ | Heart Attack |
| ___ | ___ | Stroke |
| ___ | ___ | Asthma |
| ___ | ___ | HIV/AIDS |
| ___ | ___ | Cancer - Location:_____Date:_____ |
| ___ | ___ | Tumor |
| ___ | ___ | Systemic Lupus |
| ___ | ___ | Hepatitis |
| ___ | ___ | Epilepsy |
| ___ | ___ | Diabetes |
| ___ | ___ | Rheumatoid Arthritis |
| ___ | ___ | Arthritis |
| ___ | ___ | Pregnancy |
| ___ | ___ | Incontinence |
| ___ | ___ | Other_____ |
| ___ | ___ | Tobacco Use-Packs/Day:_____ |
| ___ | ___ | Drug or Alcohol Dependence |

Present: Weight_____ Height____ft____in.
Have you fallen in the last year?____NO____YES-If yes, how many?___

**Medication List:**

| Name | Dosage | Frequency | Route Administered |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**"If you need additional room for medications please bring your med list to your next visit."**

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Hospitalization/Surgical Procedures: (list if not described elsewhere)

_____
_____
_____
_____
_____
_____

Do you have a Pace Maker:____NO____YES

Have you been exposed to COVID or had COVID: (Circle one) YES NO If yes, Date:_____