HUBBARD PHYSICAL THERAPY
PATIENT QUESTIONNAIRE

Name:_____ Date of Birth:_____

Chief Complaint: _____
_____

When did your problem begin? (Month / Year)_____

Do you have pain? No Yes If yes, where? _____

My pain can be described as: (please check all that apply)
Sharp Dull Aching Stabbing Numbness Pins & Needles

My pain is: Constant Intermittent

Please circle the number that would best rate the intensity of your pain

No Pain										Worst Possible Pain
0	1	2	3	4	5	6	7	8	9	10

Are you currently taking pain medications? (prescription or non-prescription)
No Yes If yes, please list: _____

Does the pain medication help your pain? Yes No

Please list any other medications you are taking: _____
_____
_____

Have you had any surgeries? No Yes If yes, please list: _____
_____

Please list any medical care you may have had for your current condition:

Please list any x-rays, MRIs, or CT scans you have had for your current condition:
_____

Where were they performed? _____

Please check if you have, or have ever had, any of the following?

☐ Allergies	☐ Hernia	☐ Multiple Sclerosis
☐ Angina	☐ Hepatitis	☐ Numbness or Tingling
☐ Ankylosing Spondylitis	☐ High Blood Pressure	☐ Osteoporosis/Osteopenia
☐ Arthritis	☐ Incontinence	☐ Pacemaker
☐ Asthma	☐ Infectious Diseases	☐ Parkinson's Disease
☐ Blood Clot	☐ Injury to hand	☐ Scoliosis
☐ Bowel/bladder problems	☐ Injury to knee, hip	☐ Seizures
☐ Cancer	☐ Injury to leg, foot, ankle	☐ Shingles
☐ Circulatory Problems	☐ Injury to neck, back	☐ Shortness of Breath
☐ COPD	☐ Injury to shoulder, elbow	☐ Sleeping problems
☐ Cushing Disease	☐ Joint Replacement	☐ Smoke
☐ Diabetes	☐ Kidney Problems	☐ Stroke
☐ Dizziness	☐ Latex Allergy	☐ Thyroid problems
☐ Headaches	☐ Leukemia or Lymphoma	☐ Tuberculosis
☐ Hearing problems	☐ Liver Disease	☐ Vision Problems
☐ Head Injury/concussion	☐ Memory problems	☐ Weakness
☐ Heart attack	☐ Mental Illness	☐ Weight Loss / Gain
☐ Heart surgery	☐ Metal pins or rods	

DNR ___Y ___N If yes, please provide a copy for our records

Height _____ Weight _____

Have you had a bone density test in the last 2 years? _____

Have you fallen in the past year? No Yes If yes, explain_____

Are you on your feet at least 4 hours per day? No Yes

How many hours a day do you spend: reading? _____ driving? _____ walking? _____

at the computer? _____ standing? _____ exercising? _____

Do you exercise regularly? No Yes If yes, explain how often and what type:

_____

Is there anything you would like to tell us that you think may help us treat you?

_____

_____

Patient Name (print)

_____ _____

Patient Signature (or legal guardian if patient is a minor) Date