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SOSPT, Inc.
Spine-Orthopaedic-Sport
PHYSICAL THERAPY

Name:_____ Date:_____ SOSPT #:_____

Health Status Questionnaire

The purpose of this questionnaire is to assist Dr. Fagerson by providing information regarding your health. Dr. Fagerson will review this form with you during your initial visit.

Please complete this form prior to your initial examination visit.

☐ Male ☐ Female Age:_____ Height:_____ Weight:_____

Have you ever been told you have problems with your: *Circle Y / N*		**For Clinician's Use**
Blood pressure?	Y / N	
Heart?	Y / N	
Lungs?	Y / N	
Kidney or liver?	Y / N	
Thyroid gland?	Y / N	
Blood?	Y / N	
Blood sugar levels?	Y / N	
Neurological system?	Y / N	
Circulation? Vascular system?	Y / N	
Eyes?	Y / N	
Ears?	Y / N	
Teeth, mouth, jaws?	Y / N	
Have you ever been told you have/had any of the following:		**For Clinician's Use**
Head injury?	Y / N	
Stroke?	Y / N	
Osteoporosis?	Y / N	
Neurological disease?	Y / N	
Cancer?	Y / N	
Rheumatoid arthritis?	Y / N	
Osteoarthritis?	Y / N	
Tuberculosis?	Y / N	
Repeat infections?	Y / N	
Autoimmune disease?	Y / N	
Stomach ulcers?	Y / N	
Fractures?	Y / N	
Men only: Prostate disease?	Y / N	
Women only: Endometriosis?	Y / N	
Pelvic inflammatory disease?	Y / N	
Menstrual problems?	Y / N	
Are you, or may you, be pregnant?	Y / N	

Have you recently had:		For Clinician's Use
Weight loss or gain?	Y / N	
Prolonged fevers/chills/sweating?	Y / N	
Pain at night?	Y / N	
Fatigue?	Y / N	
Joint pain or swelling?	Y / N	
Urinary or bowel problems?	Y / N	
Nausea or vomiting?	Y / N	
Numbness or tingling?	Y / N	
Weakness in arms or legs?	Y / N	
Difficulty walking?	Y / N	
Loss of balance?	Y / N	
Dizziness or loss of consciousness?	Y / N	
Chest pain?	Y / N	
Shortness of breath?	Y / N	
Difficulty swallowing?	Y / N	
Headaches?	Y / N	
Prolonged cough or hoarseness?	Y / N	
Do you smoke?	Y / N	
Any significant history of family illness?	Y / N	

List all prescription and non-prescription medications you are currently taking:

_____

_____

_____

Have you had surgery for this problem or a related problem? _____

_____

Have you had any of the following tests for your problem?

☐ x-rays ☐ MRI ☐ bone scan ☐ CT scan ☐ myelogram ☐ EMG-NCV

☐ other: _____

Have you seen anyone else for your current problem?

☐ physician ☐ physical therapist ☐ dentist ☐ podiatrist ☐ osteopath ☐ chiropractor

☐ other: _____

Who is your primary care physician? _____

Address: _____

Telephone #: _____

When was your last annual physical? _____

I, by signing below, acknowledge I have provided all my medical history information in a true manner. I understand that if I have withheld information that I may be jeopardizing my treatment.

Name (print): _____

_____ ____/____/____

Signature Date

Signature of clinician indicating review of above material: _____