53-59 Public Square, Suite 202
Watertown, NY 13601
P: 315-786-3225 / F: 315-786-3215

FYZICAL® Therapy & Balance Centers

544 Towne Drive
Fayetteville, NY 13066
P: 315-637-8800 / F: 315-637-8802

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: _____

Have you had other physical therapy or speech therapy this year? ☐NO ☐YES - If yes, how many sessions? _____

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 for this issue? ☐No ☐Yes Date ____/____/____ Procedure:_____

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

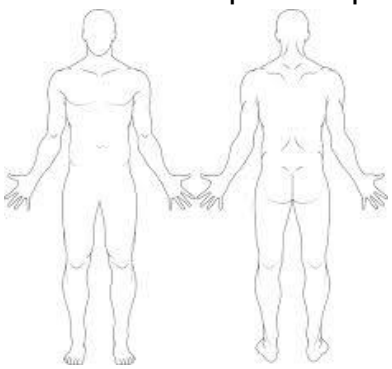
Dizziness/Imbalance:
- ☐ Spinning/vertigo
- ☐ Lightheadedness
- ☐ Imbalance
- ☐ Feeling "off"
- ☐ Motion intolerant
- ☐ Migraine/Headaches
- ☐ Ear Pressure/Pain
- ☐ Ringing in ears
- ☐ Changes in hearing
- ☐ Head Injury/Concussion

Pelvic Health:
- ☐ Leaking urine
- ☐ Bladder urgency
- ☐ Leaking bowel
- ☐ Pain in pelvic region

Symptom Frequency:
- ☐ Constant (76 – 100%)
- ☐ Frequent (51 – 75%)
- ☐ Occasional (26 – 50%)
- ☐ Intermittent (25% - or less)

Pain Description:
- ☐ Sharp Pain
- ☐ Dull (Pain) Ache
- ☐ Throbbing
- ☐ Numbness
- ☐ Shooting
- ☐ Burning
- ☐ Tingling

Please mark locations of pain on the picture



Level of symptoms at ***worst*** from 0 (No symptoms) to 10 (Unbearable symptoms) _____
Level of symptoms at ***best*** from 0 (No symptoms) to 10 (Unbearable symptoms) _____
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

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: (Name/Dosage/Frequency/Route Administered)

_____

_____

_____

_____

****If you need additional room for medications please bring a separate document on your next visit**

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

_____

_____

_____

Do you have a Pace Maker: ☐NO ☐YES