GRANITE ORTHOPAEDICS

PHYSICAL THERAPY INITIAL PATIENT QUESTIONAIRE FORM

Name: _____ Age: _____ Date: _____

Email: _____ Referring Physician: _____

Height: _____ Weight: _____ Pacemaker: YES or NO History of Cancer: YES or NO

Patient Visit Type: (Please Circle) New Return Post-op

Please answer the following questions as related to the condition for which you are attending Physical Therapy.

1. Sex: Male ___ Female ___ Right-Handed ___ Left-Handed ___ Occupation: _____ _____
2. Chief Complaint: _____ Onset date/Date of Injury: _____
3. Type of Injury/Condition: Gradual onset ___ Work Comp ___ Auto ___ Surgery ___ Sports ___ Other ___
4. Describe Your Injury/ Condition: _____
5. Type of Surgery: _____ Date of Surgery: _____
6. X-Ray Results: _____ MRI Results: _____
7. Treatment Related to Your Injury/ Condition: _____
8. Rate Your pain Using the Following Scale: **0 = NO** Pain **10 = WORST** Pain you've ever experienced

During Rest: **0 1 2 3 4 5 6 7 8 9 10**

During Activity: **0 1 2 3 4 5 6 7 8 9 10**

Past History: (Please Include Date/s)

	Yes	No	Date(s)		Yes	No	Date(s)		Yes	No	Dates (s)
Diabetes	☐	☐	_____	Gallbladder Disease	☐	☐	_____	Osteoarthritis	☐	☐	_____
High Blood Pressure	☐	☐	_____	Bladder/ Kidney Infection	☐	☐	_____	Rheumatoid	☐	☐	_____
Stroke	☐	☐	_____	Kidney Failure Dialysis	☐	☐	_____	Arthritis			
Hypothyroid	☐	☐	_____	Depression	☐	☐	_____	Fibromyalgia	☐	☐	_____
Bronchitis	☐	☐	_____	Seizures	☐	☐	_____	Pacemaker	☐	☐	_____
Emphysema	☐	☐	_____	AIDS/HIV	☐	☐	_____	Cancer	☐	☐	_____
Pneumonia	☐	☐	_____	Scarlet Fever	☐	☐	_____	(type?)_____			
Tuberculosis	☐	☐	_____	Venereal Disease	☐	☐	_____	_____			
Heart Attack	☐	☐	_____	Bleeding Disorder	☐	☐	_____	_____	☐	☐	_____
Ulcer	☐	☐	_____	Heart murmur	☐	☐	_____	Other-			
Hepatitis	☐	☐		DVT/ Blood Clot	☐	☐	_____	Please List			
Pancreatitis	☐	☐		Anemia	☐	☐	_____	_____			
							_____	_____			
								_____			

Name: _____ Date: _____

Surgical History

Have you ever had general anesthesia? ☐ Yes ☐ No Complications? ☐ Yes ☐ No

Surgery	Date	Complications

Hospitalization: _____

Injuries: _____

Family History

Family Member	Age	Alive	Deceased	Active Medical Condition/ Cause of death
Father		☐	☐	
Mother		☐	☐	
Brother/Sister		☐	☐	
Other:		☐	☐	

Social History

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Alcohol: ☐ No ☐ Yes _____ Drinks per ☐ Day ☐ Week ☐ Month

Tobacco: ☐ Current everyday smoker ☐ Current someday smoker ☐ Smoker, current status unknown

☐ Never Smoker ☐ Former Smoker ☐ Unknown if I ever smoked

Start date: _____ Quit Date: _____ Packs per day: _____

Drug Use: ☐ No ☐ Yes Name: _____ # of years: _____ ☐ Quit? _____ Years Ago

Allergies

Drug Allergies:

☐ None ☐ Penicillin ☐ Sulfas

Non-Drug Allergies:

☐ Adhesive Tape ☐ Latex ☐ Betadine

☐ Other (Please List): _____

Medications:

Medication	Dose	Medication	Dose

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Patient Consent for Evaluation/ Treatment

It is our goal to provide quality care designed to alleviate your pain and/ or maximize your physical abilities. We also teach you ways to care for yourself in order to prevent injuries in the future.

Your therapist will evaluate your injuries and tailor a treatment program to meet your individual needs. Together, we will set short- and long-term goals in an effort to facilitate your rapid recovery.

I hereby consent to physical evaluation by Granite Orthopaedics Physical Therapy. Evaluation may include any necessary examination, test or procedures ordered to be performed by the Granite Orthopaedics Physical Therapy staff. I understand that I may refuse evaluation at any time.

During your rehabilitation process, it is extremely important that you keep all your appointments and follow the instructions given by your therapist. We look forward to working with you and are committed to improving your wellbeing.

Supply Purchase Agreement

I understand this office does not bill insurance for supplies. If a therapist suggests any supply for my benefit or treatment, I understand the supply must be paid for at the time I take possession of the supply.

I understand that all supplies sold by Granite Orthopaedics Physical Therapy come into contact with the body when in use. Therefore, in compliance with the Arizona Department of Health regulations, Granite Orthopaedics Physical Therapy is unable to return to inventory stock, any supply that has left the building in the possession of the purchaser.

I acknowledge that once I purchase a supply, I will be unable to return the supply for a refund regardless of the reason. By signing below, I acknowledge my understanding that Granite Orthopaedics Physical Therapy has a NO RETURN policy for all supply purchases.

My signature below indicates that I have read and agree to all the information listed in this document.

Patient/ Legal Guardian: _____

Today's Date: _____