ASPEN VALLEY
HOSPITAL

Patient ID:

GENERAL QUESTIONNAIRE

All Questions in this Questionnaire are strictly confidential and will become a part of your medical record

What is your chief complaint/reason for coming to therapy today?	
Have you previously received therapy for this condition at another facility? Yes/No	Where:
When did it initially happen (date of injury)?	
Did it happen suddenly or gradually over time?	
Do you have pain? Yes/No If yes, what is the location of the pain? If YES please circle the number range which best quantifies your pain.	Location: Rest: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst) With Activity: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)
What Makes it Better?	
What Makes it Worse?	
Does it affect your sleep: Yes/No If Yes please describe:	
What activities do you have difficulty with at home/work/recreation due to this complaint? Please be specific:	
Have you had previous episodes/hospitalizations/treatments for this complaint? Yes/No If YES please describe:	
What are your goals for therapy? (Please be specific):	
What is your living situation? (live alone/have support; stairs or other barriers; here on vacation; etc....)	
What is your work situation? (employed/not employed; returned to work with/without restrictions; etc...)	
What diagnostic test have you had? (circle) X-RAY MRI CT SCAN BONE SCAN OTHER__________	
What pastimes or activities do you enjoy?	

Please turn over and complete the other side

Please list your current medications.
Please list allergies.
Please list past surgeries and include dates.
Please list past medical history.

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

Exercise	☐ Sedentary (No exercise)
	☐ Mild Exercise (i.e., climb stairs, walk three blocks, golf)
	☐ Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 min.)
	☐ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 min.)
Alcohol	Do you drink alcohol?
	How many drinks per week?
Tobacco	Do you use tobacco? ☐YES ☐ NO
	☐ Cigarettes-pks./day ☐ Chew-#/day ☐Pipe- #/day ☐ Cigars- #/day
	☐ # of years ☐ or year quit
Personal Safety	Do you have vision or hearing loss? ☐ YES ☐NO
	Do you have frequent falls? ☐ YES ☐NO
	Have you fallen in the past year? ☐YES ☐ NO
	Do you have a fear of falling? ☐ YES ☐NO
Other	Do you drive? ☐ YES ☐NO
	During the past month have you felt down, depressed, hopeless, and/or little or no interest in doing things ☐YES ☐ NO
	Are you pregnant? (Women only) ☐ YES ☐ NO
	Have you had any major life changes in the past year? (job change, marriage/divorce, death of a loved one, birth of a child)
	Please Describe:
	What is your preferred language?
	What style do you prefer to learn in? (Please Circle One) Verbal Visual Demonstration

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