Cheryl Ruggio PT
Hands-on Integrated Physical Therapy
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Welcome to Cheryl Ruggio PT, a physical therapy practice located within Newport Physical Therapy in Irvine.

You will be given a complete physical therapy evaluation on your first office visit. Please bring any records you may have, such as X-Ray or MRI reports. One of the goals of this first session is to learn as much as I can about you and the problems you are experiencing. To aid in this process, please complete and bring the enclosed Confidential Health Questionnaire with you to your appointment.

Attached, you will find the above-referenced health questionnaire. Please fill it out as completely as possible. This helps me understand your past medical and accident history. A blank page is included should you require additional space for writing.

I am looking forward to meeting and helping you.

Best regards,

Cheryl Ruggio

Confidential Health Questionnaire

Thank you for your cooperation and assistance in filling out this form.

Name: _____ **Date:** _____

Please answer each question. Check the appropriate box for Yes or No.

1) Are you in good health? Yes _____ No _____

2) Date of last physical examination: _____

3) Are you now under a physican's care? Yes _____ No _____

4) Have you ever had a serious illness or injury? Yes _____ No _____

If yes, please give the date of the incident, and explain. _____

_____

_____

5) Have you ever been hospitalized? Yes _____ No _____

If yes, please give the date of the incident, and explain. _____

_____

_____

6) Please list all medications, prescription and non-prescription drugs that you take regularly. Include dosage, frequency, and how long you have taken them.

_____

_____

_____

7) Please list all allergies and the type of reaction (e.g. penicillin rash).

_____

_____

_____

8) Have you ever been treated for any of the following? If yes, please provide the date of treatment/occurrence.

	YES	DATE	NO
Asthma/Wheezing			
Tuberculosis			
Chronic Chest Condition			
Frequent Colds/Sinus Issues			
Stomach/Duodenal Ulcers			
Persistent/Recurring Indigestion			
Bowel/Intestinal Trouble			
Gallbladder Stones			
Liver Trouble/Jaundice			
Colitis			
Diabetes/Sugar in Urine			
Kidney Trouble			
High Blood Pressure/Hypertension			
Heart Trouble/Murmurs/Heart Attack			
Chest Pain			
Shortness of Breath			
Chronic/Recurrent Eye Trouble			
Chronic/Recurrent Ear Trouble			
Birth Abnormalities			
Fatigue			
Insomnia			
Snoring			
Rheumatism/Arthritis			
Rheumatic Fever			
Swollen/Painful Joints			
Hernia			
Skin Disease/Rash/Acne			
Fainting Spells			
Stroke			
Paralysis			
Varicose Veins			
Epilepsy/Seizures/Convulsions			
Hemhorrhoids			
Painful or Difficult Urination			
Hypoglycemia			
Goiter/Thyroid Trouble			
High Metabolism			
Low Metabolism			
Cancer			
Anemia			
Protein/Blood/Pus in Urine			
Sexual Problems			

9) Are you currently being treated, or have you ever been treated, by a phychiatrist or psychologist?

Yes _____ No _____

10) Are you on, or applying for, disability? Yes _____ No _____

If yes, please explain the situation. _____

_____

_____

11) Are you involved in any litigation? Yes _____ No _____

If yes, please explain the situation. _____

_____

_____

Pain History

1) Please describe your chief complaint. _____

_____

_____

2) Please list chronologically (with dates included) all physicans, osteopaths, dentists, physical therapists, chiropractors, hospitals, clinics, etc., who have been involved in the problem for which you are seeking teatment. A blank page is included in the back of the questionnaire, should you require additional space.

_____

_____

_____

_____

_____

3) What treatment have you had to correct your current problem? _____

_____

_____

4) What degree of success have you had with your previous treatment? _____

_____

_____

5) Do you have any opinion as to what should be done to solve your problem?

_____

_____

6) When did your symptoms first appear? _____

7) Have they worsened? _____

8) If your condition is related to any accident, please describe the event. If you need more room, please utilize the blank page at the end of the questionnaire.

_____

_____

_____

_____

9) Did your symptoms start after an injury, intervention, or treatment?

Circle all that apply. Yes _____ No _____

Jaw	Neck	Head
Back	Extremity	Severe Emotional Upset
Flu/Virus	Dental Treatment	Orthodontic Treatment
Surgical Intervention	Digestive Problems	Car Accident

General Findings

1) Does the pain/discomfort disturb your sleep? Yes _____ No _____

2) Does the pain/discomfort interfere with your daily routine/activities?
Yes _____ No _____

3) Do you consider yourself a nervous person? Yes _____ No _____

4) Are you often depressed/unhappy? Yes _____ No _____

5) Are you easily tired? Yes _____ No _____

6) Are you easily upset? Yes _____ No _____

7) Have you ever had precious neck, shoulder, or back pain?
Yes _____ No _____

8) Do you frequently have cold hands or feet? Yes _____ No _____

9) Do your nails break frequently? Yes _____ No _____

10) Is your skin dry? Yes _____ No _____

11) Does cold weather bother you? Yes _____ No _____

12) Does hot weather both you? Yes _____ No _____

13) Please indicate anything else about yourself that you suspect may be related to your condition.

_____

_____

14) Do any of the following activites cause you pain or discomfort? Circle all that apply.

Yawning	Sitting	Bending Forward
Chewing	Work Activity	Bending Backward
Swallowing	Turning Head	Moving Arms
Singing	Turning Neck	Driving
Shouting	Turning Trunk	Walking
Speaking	Standing	Running
Brushing Teeth	In & Out of Bed	Sleeping

15) Indicate the types of pain/sensation that you experience.

Infrequent	Dull	Superficial
Intermittent	Sharp	Localized
Constant	Burning	Diffused
Deep	Throbbing	Piercing
Aching	Tingling	Shooting

16) What is the severity of your pain, with 1 being no pain, and 10 being the worst imaginable pain?

1 2 3 4 5 6 7 8 9 10

17) When is the pain or dysfunction the worst? Circle all that apply.

Morning	Afternoon	Evening
During Sleep	Upon Waking	After Awakening

Social History

1) Please list and date chronologically any change in occuplation, residence, or relationships in the last ten years (i.e. death of spouse, divorce, separation, death in family, change of financial status, etc.).

_____

_____

_____

2) Please list your hobbies and recreational activities.

_____

_____

_____

3) Please describe any regular exercises that you do.

_____

_____

Head/TMJ History

1) Does it hurt when you open your mouth wide? Yes _____ No _____

2) Does your jaw make noises so that it bothers your or others?
Yes _____ No _____

3) Do you suffer from pain in face, jaw, eyes, throat, neck or temples? Circle all that apply.
Yes _____ No _____

Face	Eyes	Neck
Jaw	Throat	Temples

4) Do you suffer from headaches? Yes _____ No _____

5) Do you grind your teeth in your sleep? Yes _____ No _____

6) Are you aware that you 'clam' or 'set' your teeth? Yes _____ No _____

7) Do you have any of the following symptoms upon awakening? Circle all that apply.

Stiff Jaw	Sore Jaw/Teeth
Headache	Cracking/Locking Jaw

8) Does your jaw feel 'tired' after a big meal? Yes _____ No _____

9) Must you chew on one side exclusively? Yes _____ No _____

If yes, which side? Left _____ Right _____

Digestive History

1) How long have you had abdominal pain? _____

2) Do you have more than one pain? Yes _____ No _____

If yes, how many different pains do you have? _____

3) Where is the worst pain located? _____

4) How often does the pain occur and how long does it generally last? _____

_____

5) Does the pain ever wake you up? Yes _____ No _____

6) Is the pain ever so severe that it is unbearable and interferes with daily life?
Yes _____ No _____

7) How would you describe the pain (i.e. cramping, aching, stabbing, etc.)? _____

_____

8) Have you found anything you can do or take to alleviate the pain?
Yes _____ No _____

9) Does eating or drinking make the pain better or worse? _____

_____

10) Have you identified certain foods tha tseem to trigger pain or diarrhea? _____

_____

11) Describe your typical pattern of bowel movements and the consistency of your feces (ex: one bowel movement every three days with difficulty to pass).

_____

_____

_____

12) Has this pattern remained constant or has it changed in recent months? _____

_____

13) Is the pain relieved after a bowel movement? Yes _____ No _____

14) Do you have any of the associated symptoms? Circle all that apply.
Yes _____ No _____

Bloating	Gas	Vomitting
Nausea	Belching	

15) Have you lost weight in recent months? Yes _____ No _____

If yes, how much and over what time period? _____

16) Have you been previously evaluated for these complaints?

Yes _____ No _____

17) Have you been previously evaluated for these complaints?

Yes _____ No _____

18) Please give your opinion on the effectiveness or side effects of any previously prescribed medications that you have taken for your complaints.

_____

_____

_____

19) Do you smoke? Yes _____ No _____

20) Do you consume alcohol? Yes _____ No _____

Additional Comments:

_____ _____

Patient Name **Date**

_____

Patient Signature

Additional Page