

Name: _____ Date: _____ Age: _____

Patient Questionnaire

Please bring a hard copy of this form to your appointment. To maintain your privacy, please do not email or fax this form to us.

1. Describe the problem that brought you to physical therapy:

2. When and how did it start? _____

3. Please mark on the drawing the area(s) of discomfort:

4. Have you ever had this problem, before?

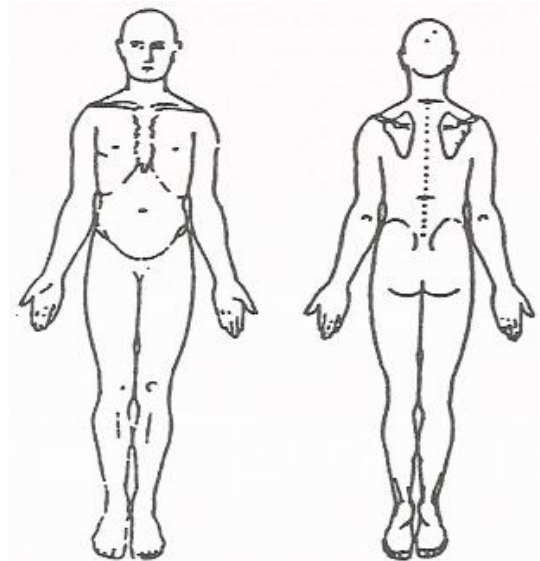
If yes, (a) please describe: _____

(b) Did you receive treatment for it? _____

5. Mark on the scale below the level of discomfort

0----1----2----3----4----5----6----7----8----9----10

0=No pain 10=Needs emergency



6. Circle all the words that describe your pain:

Intermittent Constant Deep Superficial Sharp
Dull Radiating Numb Throbbing
Burning Cold Stabbing

7. Which activities increase your symptoms?

Sitting Walking Kneeling Twisting Standing Reaching
Reclining Lifting Bending Stairs Rising from a Chair

Other: _____

8. What eases your symptoms? Heat Ice Medication Rest Change in position

Other _____



Name: _____

9. When is the pain worse? Morning Evening Night
Does it wake you at night? Yes No

10. Your occupation: _____

11. Are you able to keep working? Yes No Full time Part time
If yes, are you on work restriction? _____

12. Are the physical demands of your job: Light Moderate Heavy
Please describe _____

13. Are you able to continue with recreational activities? Yes No
If no, please describe _____

14. What are the goals and expectations for Physical Therapy?

Medical information:

15. What types of test have you had? X-ray MRI CAT Scan Bone Scan
Results: _____

16. What surgeries have you had and when? _____

17. Are you currently taking any medications? Yes or No
Please list: _____

18. Please list any health history that would be important for us to know:
(Diabetes, Cancer, Osteoporosis, Heart Disease...etc)

19. (Females only): Are you Pregnant? Yes No Attempting Pregnancy? Yes No