

# Physical Therapy Patient Questionnaire

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Gender: M/F

Age: \_\_\_\_\_

Smoker: Yes/No

Latex Allergies: Yes / No

Pregnant: Yes / No

Occupation: \_\_\_\_\_

## Past Medical History: Check any condition that you have or had:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Parkinson Disease       | <input type="checkbox"/> Kidney Problems           |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Infectious Disease      | <input type="checkbox"/> Multiple Sclerosis        |
| <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Thyroid Problems        | <input type="checkbox"/> Broken Bones/Fracture     |
| <input type="checkbox"/> Allergies/Asthma    | <input type="checkbox"/> Skin Disease            | <input type="checkbox"/> Liver Disease             |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Ulcers/Stomach Problems | <input type="checkbox"/> Head Injury               |
| <input type="checkbox"/> Heart Problems      | <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Sexually Transmitted Dis. |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Depression              | <input type="checkbox"/> Lung Problems             |
| <input type="checkbox"/> Seizures/Epilepsy   | <input type="checkbox"/> Fibromyalgia            | <input type="checkbox"/> Pace maker                |
| <input type="checkbox"/> Other _____         |  |  |

Past Surgical History: \_\_\_\_\_

Current Medications: \_\_\_\_\_

## Are you currently experiencing:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Unexplained weight loss             | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Difficulty swallowing   |
| <input type="checkbox"/> Depression                          | <input type="checkbox"/> Nausea/Vomiting      | <input type="checkbox"/> Headaches               |
| <input type="checkbox"/> Change in bowel or bladder function | <input type="checkbox"/> Poor Balance (falls) | <input type="checkbox"/> Increased pain at night |
| <input type="checkbox"/> Numbness or tingling                | <input type="checkbox"/> Change in appetite   |  |
| <input type="checkbox"/> Shortness of breath                 | <input type="checkbox"/> Fever/Chills/Sweats  |  |

## Have you had a history of balance issues?

- 2 or more falls in the past year
- Any fall in the past year that resulted in injury
- No falls, or only one but without injury

## Are you using an assistive device?

- Crutches  Brace  Walker  WheelChair
- Cane  Splint  Other \_\_\_\_\_

## Current Employment / Work:

- Full time  Part time  Student  Unemployed  Disabled  Working light duty due to injury
- Not working due to injury

What date (*approximately*) did your present pain start? \_\_\_\_\_

How? (*gradually, suddenly, injury*) \_\_\_\_\_

My symptoms are currently:  getting better  about the same  getting worse

What treatments have you received for this problem so far? \_\_\_\_\_

Have you had an X-ray, MRI or other tests for this problem? \_\_\_\_\_

Is your pain affecting your sleep? Yes/No

What makes your symptoms *better*? \_\_\_\_\_

What makes your symptoms *worse*? \_\_\_\_\_

**PLEASE TURN OVER AND COMPLETE BACK OF FORM**

Signature: \_\_\_\_\_ Therapist Signature: \_\_\_\_\_

### On Body Diagram

Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not include areas of pain which are not related to your present problem.

///// Stabbing	XXX Burning	0000 Pins & Needles	= = = Numb
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Pain frequency:    Less than daily    Daily    Increases throughout the day    Constant    Night Pain  
 Other (*please explain*) \_\_\_\_\_

On the scale below, please circle the number which represents the average level of pain you have experienced over the last 48 hours:

*No Pain*
*Worst Pain Imaginable*  
0   1   2   3   4   5   6   7   8   9   10

**CHECK ALL THOSE THAT APPLY:**

What percentage of your normal **WORK** activities are you able to perform currently?

0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

What percentage of your normal **HOME** activities are you able to perform currently?

0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

What percentage of your normal **RECREATIONAL** activities are you able to perform currently?

0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

Identify 3 goals that you personally would like to achieve as a result of your therapy:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Is there anything else we should know about your symptoms or medical history?

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