Patient Initial Questionnaire

Name: _____ Date: _____

1. When did your symptoms begin? _____Most recent exacerbation_____

2. What are your reasons for seeking physical therapy? _____
_____

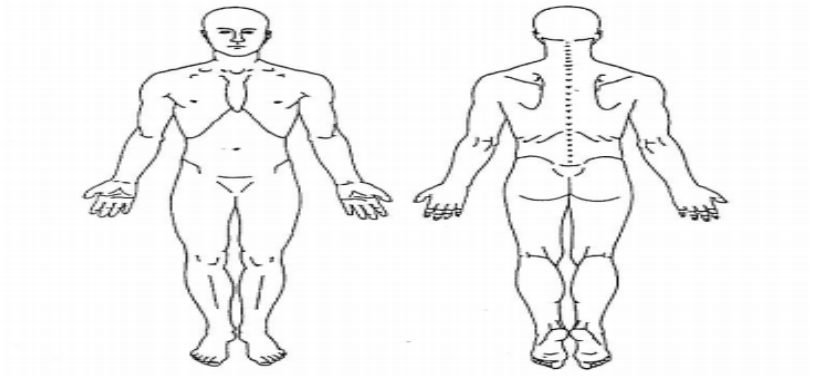
3. Was surgery performed? ☐ Yes ☐ No Date of Surgery_____ Hospitalization? ☐Yes ☐No

4. Mechanism of Injury or how did your injury occur? _____
_____

5. Did your symptoms come on ☐suddenly or ☐gradually or ☐Other_____

6. Describe your symptoms (use diagram to mark areas and check words below to assist)
_____
_____

- Please draw/shade the diagram below where you have symptoms.
- Check/circle the words that apply: ☐achy ☐ sharp ☐throbbing ☐ dull ☐numb ☐tingling ☐constant ☐occasional ☐ other:_____



7. Please rate your current pain level 0 through 10 (0=no pain, 10=worst pain imaginable)
0 1 2 3 4 5 6 7 8 9 10
Today_____ Worst_____ Best_____.

8. Does the pain wake you at night? ☐ No ☐ YES, how many times? _____ x/night/week.
What position do you prefer to sleep in? ☐back ☐Right or ☐ Left side ☐stomach ☐All

9. Have you had similar symptoms or injuries in the past? ☐No ☐Yes –how many times_____ .
How long ago?_____ Describe_____

10. Are your symptoms getting ☐better, ☐worse, or ☐staying the same?
11. As day progresses are your symptoms ☐better ☐ worse ☐no change.
12. Are your symptoms ☐constant or ☐intermittent (come and go)?
13. Do your symptoms move around? ☐Yes ☐No. Describe. _____

14. What are they activities that you are **unable** to do because of your symptoms?

15. What positions or activities **aggravates** your symptoms or makes them worse? Mark all that apply and add more under other.

☐sitting	☐rising from sitting	☐standing	☐squatting
☐ walking	☐stairs up/down	☐repetitive activities	☐reaching
☐bending	☐recreation/sports	☐household/gardening	☐stress
☐sleeping	☐looking overhead	☐ others_____	
☐swallowing			
☐cough/sneezing			

16. What activities or positions **relieve** your symptoms?

☐Sitting,	☐lying	☐rest	☐walking	☐exercise, type_____
☐ stretching	☐massage	☐heat	☐cold	☐traction
☐ medications_____		☐nothing	☐other_____	

17. Are you currently working? ☐ No ☐ Yes. Occupation:_____
What positions do you work in? _____Percentage sitting____%, standing____%, lifting___%, bending___% driving____% other _____

18. Do you exercise regularly beyond daily activities? ☐Yes. ☐No.
What type exercise/sport_____
Please list other activities or hobbies you enjoy_____

19. What goals would you like to accomplish in physical therapy (activities you'd like to do again)
1.
2.
3.

20. Have you experienced any of the following medical symptoms? Check all that apply.

___Bladder or bowel dysfunction	___Generalized weakness
___Fever/chills	___Unexplained weight loss or gain
___Genital/ saddle area numbness	___Night pain/Sweats
___Numbness in BOTH arm/ legs	___Malaise –generally unwell, fatigue
___Dizziness	___Vision Disturbance/Changes in hearing
___Speech/swallowing difficulty	
___Fainting or Falls (how many)? _____	

21. What other treatments have you had for this condition? (chiro/DC/DO, naturopathic, acupuncture, massage, injections etc) circle or add _____

22. Have you had any imaging (x-ray, MRI, CT) done? ☐No ☐ Yes. Results: _____
23. Past surgeries to anywhere in you body? ☐No. ☐Yes: What/Where/Why?_____
24. List past fractures, dislocations, sprains, motor vehicle accidents, traumas:_____
_____

25. **Medical History (circle all that apply and see separate sheet for more detail)**:

Blood disorder	Hormonal	Currently Pregnant
Cancer	Infections (HIV/AIDS,	Other:
Depression/Anxiety	Lyme)	
Diabetes	Kidney	Please describe anything in
Drug abuse	Neurologic	more detail here or on
Gastrointestinal	Reproductive	separate sheet>
Heart or Lung Disease	Rheumatologic	
High blood pressure	Skin	
High cholesterol	Vascular	

26. List current medications: