MARIN IPA
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Core Physical Therapy

Patient Information Questionnaire

Name:	Age:	Occupation:	Contact Phone #:

Why have you come for physical therapy?_____

_____

_____

Date of Injury/Date of Surgery:_____

Prior to this current event were you completely free from symptoms? (_) yes (_) no _____

_____

Please circle on the scale below your pain level **at its best (lowest level)** and **at its worst (highest level)?**

0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain)

What is your **average or usual** level of pain on the scale between 0-10? _____ out of 10.

What makes the pain better?_____

What makes the pain worse?_____

Do you have any **specific functional limitations or daily activities** in which you are **currently** unable to participate because of your pain or symptoms?_____

_____

What, if any, treatments have you had for this current problem?_____

_____

Are you getting (_) Better (_) Worse (_) Same _____

Medical History

Are you presently taking any medications (including over the counter)? (_) no (_) yes (please list)_____

_____

Do you have or have you ever had any of the following?

(_) Cancer	(_) Heart Attack	(_) Osteoporosis
(_) Diabetes	(_) Heart Disease	(_) Hernia (ventral, inguinal, etc)
(_) High Blood Pressure	(_) Pacemaker	(_) Adverse Reactions to Medicine
(_) Seizures	(_) Respiratory Difficulty	(_) Other Allergies_____
(_) Previous Surgery	(_) Dizziness	(_) Pregnancy (Current or Past)

If marked any of the above, please explain and include approximate dates:_____

_____

_____

_____

Is there anything else you think we should know?_____

_____

_____

The undersigned acknowledges and agrees that the information set forth herein is true and correct.

Date:_____ Signature:_____

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