



Patient Questionnaire

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Contact Phone #: \_\_\_\_\_

Person completing form (if not patient): \_\_\_\_\_ Relationship: \_\_\_\_\_

Occupation: \_\_\_\_\_ Are you currently working? (Y) or (N): \_\_\_\_\_

Why have you come for physical therapy? \_\_\_\_\_

Date of onset, injury, or surgery related to this visit: \_\_\_\_\_

Have you recently had an x-ray, MRI, or other test for your condition? (N) or (Y) If yes, approx. date: \_\_\_\_\_

Findings: \_\_\_\_\_

Prior to this current event were you completely free from symptoms? (Y) or (N). If no, how long have symptoms been present? \_\_\_\_\_

Are symptoms (Better) (Worse) or (Same) since onset? \_\_\_\_\_

On scale below, please circle lowest, highest, and average pain you've experienced in the past week:

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

What is your pain level today? \_\_\_\_\_ out of 10.

What makes the pain worse? \_\_\_\_\_

What makes the pain better? \_\_\_\_\_

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? \_\_\_\_\_

If you've had prior physical therapy for your symptoms, how long ago was this? \_\_\_\_\_

What was the outcome? \_\_\_\_\_

Medical History

Are you presently taking any medications (including over the counter)? (N) or (Y), If yes, please explain: \_\_\_\_\_

Please list any other major surgeries or hospitalizations not related to this condition :

Surgery/hopitalization: \_\_\_\_\_ Approx. Date: \_\_\_\_\_

Reason: \_\_\_\_\_

Surgery/hopitalization: \_\_\_\_\_ Approx. Date: \_\_\_\_\_

Reason: \_\_\_\_\_

(This is a 2-sided form; please turn over to complete)

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please circle "N"=no, "Y"=yes below. Please explain any "yes" answers on line provided.

Unexplained weight loss/gain (N) or (Y): \_\_\_\_\_

Any long-term oral steroid use (N) or (Y): \_\_\_\_\_

Any long-term oral anticoagulants use (N) or (Y): \_\_\_\_\_

Pain with cough or sneeze (N) or (Y): \_\_\_\_\_

Constant pain unrelieved by rest (N) or (Y): \_\_\_\_\_

Night pain(wakes you from sleeping) (N) or (Y): \_\_\_\_\_

History of falls (N) or (Y): \_\_\_\_\_

Calf pain with exercise (N) or (Y): \_\_\_\_\_

Any night fever or night sweats? (N) or (Y): \_\_\_\_\_

**Any unexplained or sudden onset of the following?**

Dizziness (N) or (Y): \_\_\_\_\_

Blurred vision or other visual problems (N) or (Y): \_\_\_\_\_

Problems speaking or swallowing (N) or (Y): \_\_\_\_\_

Fainting (N) or (Y): \_\_\_\_\_

Nausea or vomiting (N) or (Y): \_\_\_\_\_

Changes in bowel or bladder function (N) or (Y): \_\_\_\_\_

Memory loss/changes in mental status (N) or (Y): \_\_\_\_\_

**Any numbness or tingling in the following areas?**

both hands at same time (N) or (Y): \_\_\_\_\_

both feet at same time (N) or (Y): \_\_\_\_\_

saddle area\* (N) or (Y): \_\_\_\_\_

(\* saddle area is region between legs that would contact a saddle if you sat in one while riding a horse)

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

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Stroke                | <input type="checkbox"/> Chest Pain or Discomfort at Rest or During Activity |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Heart Attack          | <input type="checkbox"/> Trouble Breathing Lying Flat                        |
| <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Osteoporosis  |
| <input type="checkbox"/> Seizures                | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Hernia (ventral, inguinal, etc)                     |
| <input type="checkbox"/> Stomach/Bowel Disorders | <input type="checkbox"/> Lung Disease/Problems | <input type="checkbox"/> Other Allergies: _____                              |
| <input type="checkbox"/> Abdominal Pain          | <input type="checkbox"/> Shortness of Breath   | <input type="checkbox"/> Pregnancy (Current or Past)                         |

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of person completing form: \_\_\_\_\_ Date: \_\_\_\_\_  
(if not patient)