first step physical therapy

Patient Name_____

Patient Questionnaire

Describe the problem for which you seek therapy_____
_____

When did the problem begin (date)? _____

Did you have surgery ☐ Yes ☐ No Date of surgery?_____

What happened: _____
_____

What is your primary concern/chief complaint?_____
_____

Is this the result of a car accident or fall? If yes, describe _____
_____

Have you ever had this problem before? ☐ Yes ☐ No
If yes, what did you do for the problem? _____

What are you having a problem doing as a result of the injury?
☐ Sleeping ☐ Self Care ☐ Standing ☐ Reaching/pushing/Pulling
☐ Lifting/Carrying ☐ Sitting/Standing ☐ Walking ☐ Driving
☐ Sports_____ ☐ Other_____

Employment/Work? Name of Occupation_____
☐ Fulltime ☐ Part-time ☐ Retired ☐ Student ☐ unemployed ☐ Other_____
Describe duties_____
_____

What procedures have you had for this problem? (Check all that apply)
☐ Xray ☐ MRI ☐ CT ☐ Injections/blocks ☐ Surgery
☐ Other _____

Are you taking any medications for the condition described above?
☐ Yes ☐ No If yes, please list _____
_____

How are you taking care of the problem now? _____

What makes the problem better? _____
_____

What makes the problem worse? _____
_____

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Pain:

Pain Rating: Please rate your pain using the numeric scale listed below.
A rating of 0 means you have no pain at all.
A rating of 10 means that your pain is unbearable and you should go to the Emergency Room Immediately.

PLEASE RATE YOUR PAIN AT ITS BEST

0	1	2	3	4	5	6	7	8	9	10
No Pain				Moderate Pain						Intense Pain – Go to ER

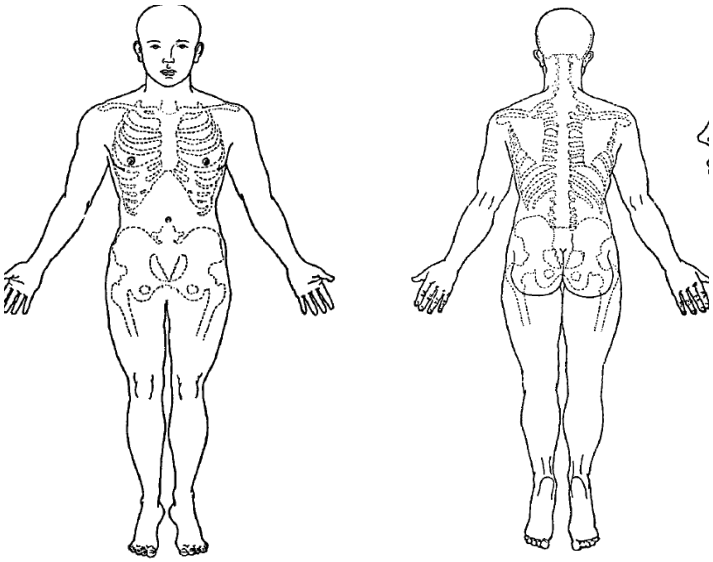
PLEASE RATE YOUR CURRENT PAIN

0	1	2	3	4	5	6	7	8	9	10
No Pain				Moderate Pain						Intense Pain – Go to ER

PLEASE RATE YOUR PAIN AT ITS WORST IN THE LAST 2 WEEKS

0	1	2	3	4	5	6	7	8	9	10
No Pain				Moderate Pain						Intense Pain – Go to ER

Please shade on the diagram below the location of your problem/pain.



Describe your pain:
☐ Sharp ☐ Dull ☐ Aching ☐ Shooting ☐ Throbbing ☐ Other_____

Is your pain ☐ Constant ☐ Intermittent ☐ Variable

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Medical History (Please check all the apply):

List any medications (on the same line) that you are taking for this condition:

☐ Coronary Artery Disease_____
☐ Heart Murmurs_____
☐ Angina (Chest pain) _____
☐ Arrythmias (Irregular heartbeats) _____
☐ Heart Attack _____
☐ **PACEMAKER – date**_____
☐ High blood pressure_____
☐ Stroke_____
☐ Diabetes_____
☐ Epilepsy/Seizures _____
☐ Cancer – Type:_____
☐ Lung Disease (COPD, Asthma, Emphysema…..) – Please Explain _____
☐ Arthritis Type: ☐ Rheumatoid ☐ Osteoarthritis
Where: _____
_____
☐ Osteoporosis _____
☐ Surgery – Where/When _____
_____
☐ Allergies – Please list _____
☐ Hernia (or any condition which can be aggravated with lifting) _____
☐ Memory Loss/Alzheimer's/Dementia _____
☐ Circulation/Vascular Problems _____
☐ Problems with swelling _____
Where: _____
☐ Broken Bones (list location)_____
_____
☐ Balance Disorder _____
☐ Vertigo _____
☐ Depression _____
☐ Other – Please List _____
_____

Patient's Signature _____ **Date** _____

Therapist Signature_____ **Date** _____