

NAME \_\_\_\_\_  
MD \_\_\_\_\_  
MEDICAL RECORD \_\_\_\_\_

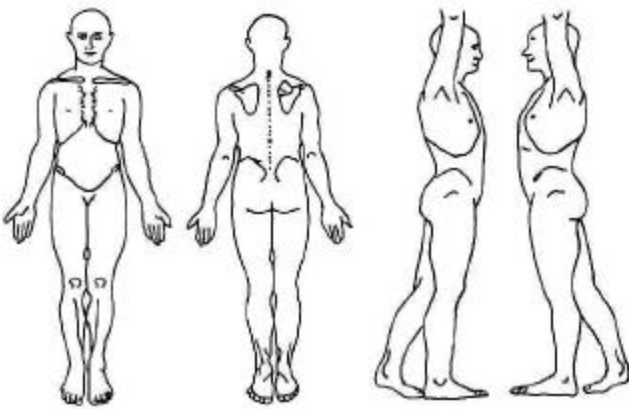


### PHYSICAL THERAPY QUESTIONNAIRE

1. How and when (date) did the present injury occur? \_\_\_\_\_  
\_\_\_\_\_

2. What are your functional problems with this condition? \_\_\_\_\_  
\_\_\_\_\_

3. Indicate on body diagram where your pain is located.



4. On a scale of 0-10 (10 being excruciating) how painful was it when it started? (circle number)  
1 2 3 4 5 6 7 8 9 10

5. What is it at its best and worst? (circle number)  
1 2 3 4 5 6 7 8 9 10

6. How is it today? (circle number)  
1 2 3 4 5 6 7 8 9 10

7. Describe the pain (i.e. sharp, dull, ache, numb, etc)  
\_\_\_\_\_

8. What activities make your pain worse? \_\_\_\_\_  
\_\_\_\_\_

9. What if anything eases your pain? \_\_\_\_\_  
\_\_\_\_\_

10. Do you have any problems with your bowel or bladder? \_\_\_\_\_

11. Have you had anything similar before? \_\_\_\_\_

12. What started this problem? \_\_\_\_\_

13. Have you had diagnostic medical tests for this, if so where can they be located? \_\_\_\_\_

14. Please list all medications, dosage, and purpose.

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15. Do you smoke tobacco? \_\_\_\_\_

16. Please list all surgeries and approximate dates.

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17. Have you seen any one else for this problem? If so, please list.

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18. Do you exercise regularly? \_\_\_\_\_

**Past or current medical history check all that have had or now have:**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart disease           | <input type="checkbox"/> Chest pain       | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Lung disease        | <input type="checkbox"/> Heartburn               | <input type="checkbox"/> Upset stomach    | <input type="checkbox"/> Thyroid condition    |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Low blood sugar         | <input type="checkbox"/> Cancer           | <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Joint disease           | <input type="checkbox"/> Headaches        | <input type="checkbox"/> Swelling             |
| <input type="checkbox"/> Fractures           | <input type="checkbox"/> Vision problems         | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Arthritis            |
| <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Psoriasis               | <input type="checkbox"/> Stroke           | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Dizziness/Fainting  | <input type="checkbox"/> Metal or other implants | <input type="checkbox"/> Tumor/cyst       | <input type="checkbox"/> Epilepsy/Seizures    |
| <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> other                   |   |   |

19. How do you hope therapy will help you? \_\_\_\_\_

To the best of my knowledge, the information I have provided is accurate and complete.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist's Signature