



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

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

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Hand Dominance:  Right  Left

1. What is the problem/diagnosis we are seeing you for? \_\_\_\_\_

2. When did it begin? \_\_\_\_/\_\_\_\_/\_\_\_\_

3. Which of the following best describes how your problem/injury began?

- Lifting                       Trauma                       Overuse
- Car Accident               Degenerative Process       Unknown
- A Fall                         Recreational/Sports         Other: \_\_\_\_\_

4. Where did your injury/problem occur?

- Auto    Work    Home    Other Premise    Unsure    Other: \_\_\_\_\_

5. Have you retained an attorney?  No  Yes      If yes, are you in litigation?  No  Yes

6. Please check any of the following symptoms that you are experiencing.

- Pain    Limited Motion    Numbness/Tingling    Swelling    Weakness    Other: \_\_\_\_\_

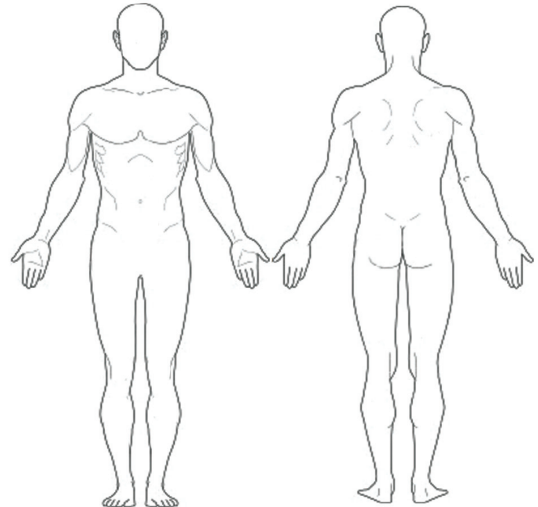
7. Please rate your pain on a scale of 0 to 10 (Zero = No pain, 10 = Unbearable): \_\_\_\_\_

**Rate your pain on a scale of 0 to 10**

with the following activities:

- Walking: \_\_\_\_\_
- Standing: \_\_\_\_\_
- Sitting/Driving: \_\_\_\_\_
- Bending: \_\_\_\_\_
- Sleeping: \_\_\_\_\_
- Changing Positions: \_\_\_\_\_
- Lifting:    General: \_\_\_\_\_
- Laundry Baskets: \_\_\_\_\_
- Groceries: \_\_\_\_\_
- Reaching Over the Head: \_\_\_\_\_
- Reaching Behind the Back: \_\_\_\_\_
- Looking Over the Shoulder: \_\_\_\_\_

**Shade any painful areas:**



8. Does your pain wake you at night?  No  Yes

What position do you normally wake in? \_\_\_\_\_ What is your preferred sleep position? \_\_\_\_\_

9. Have you had similar problems in the past?  No  Yes      If yes, when? \_\_\_\_\_

10. What makes your symptoms worse?

- Weather    Prolonged Activity    Time of Day    Certain Positions    Other: \_\_\_\_\_

Please proceed to page 2



11. What relieves/lessens your symptoms?

- Medication Rest Heat Ice Exercises Other:

12. What previous treatments have you had?

- None Medication Massage Therapy Physical Therapy Bracing/Taping Manipulation/Adjustment by a Chiropractor or Osteopath Injections Exercise Other: TENS unit

13. Check if you have had any of the following tests for this problem within the last 6 months.

- MRI Arthroscopic Eval Bloodwork CT Scan EKG EMG X-Ray Myelogram Other:

14. Have you had any surgeries? No Yes If yes, please list type(s) and date(s):

Were any of the above tests or surgeries for the problem we are seeing you for? No Yes

15. Are you currently working? No Yes Part Time Full Time Restricted Duty

Occupation (specific):

Are there any job tasks you are having difficulty with?:

16. List any medications you are taking (include over the counter)

17. Do you have any drug allergies? No Yes If yes, please list:

18. Are you allergic to latex? No Yes

19. Have you had, or do you currently have, any of the following medical conditions:

- Cancer Seizures Hernia Heart Disease CVA/Stroke Recent Surgery (this year) Diabetes Breathing Difficulties High Blood Pressure Joint Replacement Pacemaker Gout Pregnant (currently) Arthritis Type(s): Other:

20. What goals do you wish to achieve from Physical Therapy?

Thank you for completing this questionnaire.