PRO·MOTION PHYSICAL THERAPY

Join the *Movement*

# Questionnaire

**Why were you referred to Physical Therapy by your physician?** _____

_____

**How long have you had this problem?** _____

**When did this problem start?** _____

**Have you had similar problems in the past?** ___ Yes ___ No If yes, when?_____

**Is your problem related to an injury?** ___ Yes ___ No

**How did your problem start or where and how did the injury happen?** _____

_____

**What treatment have you previously received for this problem?**

___ Physical Therapy ___ Occupational Therapy ___ Chiropractic Care ___ Bed Rest

___ Surgery ___ Medications _____

___ Other _____

**What test have you received for this problem?**

___ Bone Scan
When _____
_____

___ X-Rays
When _____
_____

___ MRI Scan
When _____
_____

___ CAT Scan
When _____
_____

___ EMG/NCV
When _____
_____

___ Myelogram
When _____
_____

**Please rate your current ability to function with your everyday activities as a result of your problem or injury.**

___ 0% ___ 25% ___ 50% ___ 75% ___ 100%

**Check all the activities that you have trouble performing as a result of your present condition.**

___ Bathing ___ Child Care ___ Dressing ___ Eating

___ Homemaking ___ Sexual Intercourse ___ Sitting ___ Sleeping

___ Standing ___ Walking ___ Working ___ Yard Work

*continued on next page*

**How long can you tolerate the following?**

| | *Less than 30 minutes* | *1 - 2 Hours* | *3 - 4 Hours* | *No Problems* |
|---|---|---|---|---|
| Walking | ___ | ___ | ___ | ___ |
| Sitting | ___ | ___ | ___ | ___ |
| Standing | ___ | ___ | ___ | ___ |

**Occupation:** _____

**Hobbies:** _____

**Job Demands:**

**Lifting/Carrying**

___ 10 lbs. or Less ___ 10 - 15 lbs. or Less ___ 15 - 25 lbs. ___ 25 - 50 lbs. ___ 50 or More lbs.

**Frequency**

___ 1 Hour or Less ___ 1 - 2 Hours ___ 2 - 4 Hours ___ 4 - 6 Hours ___ 6 or More Hours

**Repetitive Arm Use**

___ 1 Hour or Less ___ 1 - 2 Hours ___ 2 - 4 Hours ___ 4 - 6 Hours ___ 6 or More Hours

**Sitting**

___ 1 Hour or Less ___ 1 - 2 Hours ___ 2 - 4 Hours ___ 4 - 6 Hours ___ 6 or More Hours

**Standing**

___ 1 Hour or Less ___ 1 - 2 Hours ___ 2 - 4 Hours ___ 4 - 6 Hours ___ 6 or More Hours

**Walking**

___ 1 Hour or Less ___ 1 - 2 Hours ___ 2 - 4 Hours ___ 4 - 6 Hours ___ 6 or More Hours

**At this time are you working:** ___ Full Time ___ Light Duty ___ Part Time ___ Off Work

**Please place a mark through the line below to indentify the severity of your pain**

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| At Rest | *No Pain* | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | *Most Severe Pain* |
| With Activity | *No Pain* | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | *Most Severe Pain* |

**Describe Your Pain**

| | | | |
|---|---|---|---|
| ___ Constant | ___ Comes and Goes | ___ Dull Ache | ___ Sharp |
| ___ Burning | ___ Throbbing | ___ Shooting | |
| ___ Worse in Morning | ___ Worse in Afternoon | ___ Worse at Night | ___ Other |

*continued on next page*

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# Questionnaire *cont'd*

**My pain is better when I** _____

**My pain is worse when I** _____

**Can you sleep comfortably despite your pain?** ___ Yes ___ No

**Do you have numbness associated with your pain?** ___ Yes ___ No

Where? _____

## Medical History

**Indicate below if you have any of the following:**

___ High Cholesterol ___ Diabetes ___ Asthma ___ Cancer ___ Migraine

___ Stroke ___ Arthritis ___ Seizures ___ Heart problems ___ Ear

___ Bladder ___ Fractures ___ Kidney infections

___ Circulatory problems ___ High Blood pressure

___ Other: _____

**Do you smoke?** ___ Yes ___ No ___ packs per day

**Weight** _____

**Height** _____

**Are you Pregnant?** ___ Yes ___ No LMP: _____

**List medications you are taking:** _____

_____

_____

**List previous surgeries/dates:** _____

_____

_____

**Is there any other pertinent information we need to know?** _____

_____

**When is your next doctor's appointment?** _____

**What do you wish to accomplish in Physical Therapy?** _____

**X** _____ _____

*Patient Signature* *Date*

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