Pre-Exam Questionnaire

1. Is this the first time you have been to physical therapy for any condition? □ Yes □ No

2. Have you ever had this pain or problem before? □ Yes □ No

2a. If yes, did you receive any treatment? □ Yes □ No If yes, where?

3. List the dates and results of any: □ X-Rays: □ MRIs:

4. Where is your pain or problem? □ Neck □ Lower Back □ Middle Back □ Other:
□ Right □ Left □ Both □ Elbow □ Wrist/Hand □ Shoulder/Upper Arm
(check all that apply) □Hip □ Knee □ Foot/Ankle

5. Does the pain or problem: □ Move □ Stay In One Place Is the pain or problem: □ Deep □ On the surface

6. When did this problem first begin? _____/_____/_____

7. What caused your pain or problem?

8. My pain/problem is slowly getting: □ worse □ better □ staying the same

9. My pain/problem bothers me: □ constantly □ most of the time □ only occasionally □ once in awhile

10. On a scale from 0 to 10, what is the worst your pain/problem has been in the past several days? _____/10

Mild discomfort *Moderate* *Unbearable, Severe*

0 . . . . . 1 . . . . . 2 . . . . . 3 . . . . . 4 . . . . . 5 . . . . . 6 . . . . . 7 . . . . . 8 . . . . . 9 10

10. Do you have any regular numbness or tingling? □ Yes □ No

11. What seems to make your pain/problem worse?

12. What seems to make it feel better?

13. Are you taking any medication for this pain/problem? □ Yes □ No
If yes, what are you taking and does it help?

14. Are any of your usual everyday activities affected? □ Yes □ No

14a. If yes, describe how:

15. List all past surgeries with dates:

16. Do you have, or have you had any of the following?

□ Diabetes	□ Pacemaker	□ Cancer	□ Seizures	□ Stroke/CVA
□ High Blood Pressure	□ Hernia	□ Osteoporosis	□ Fractures	□ Current Pregnancy
□ Heart Disease	□ Metal Implants	□ Bowel Abnormalities	□ Asthma	□ Neuropathy
□ Heart Attack	□ Headaches	□ Urine Leakage	□ Rheumatoid Arthritis	□ _____
□ Heart Palpitations	□ Dizziness / Fainting	□ Urine Retention	□ Osteoarthritis	□ _____
□ Angina	□ Anxiety	□ COPD	□ Degenerative Disc	□ Allergies:_____
□ Congestive Heart Failure	□ Sleep Disorder	□ Depression	□ Spinal Stenosis	□ Allergies:_____

_____ _____ ___/___/20___
Patient Name Signature Today's Date

Reviewed By:____