FLEX physical therapy

Date:_____

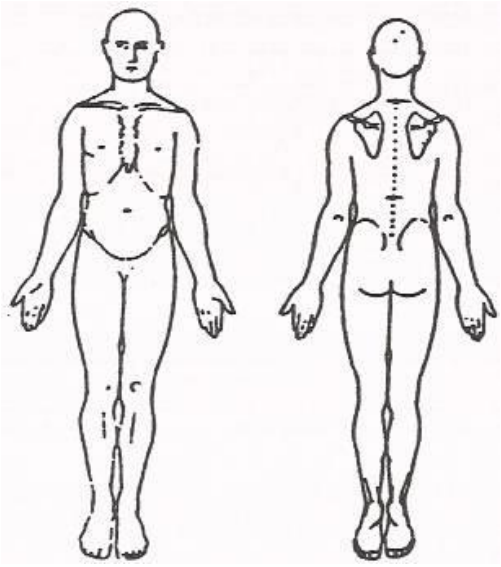
Name:_____ Age: _____

## Patient Questionnaire

1. Describe the problem that brought you to physical therapy:

_____

_____



2. When did it start? _____

How did it start? _____

3. Please mark on the drawing the area(s) of discomfort:

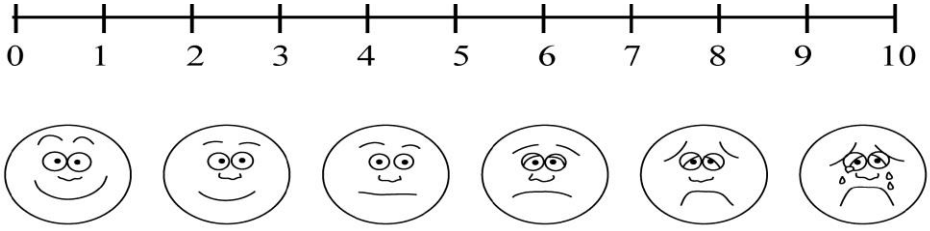
4. Have you ever had this problem, before?
If yes, (a) please describe: _____

_____

(b) Did you receive treatment for it? _____

_____

5. Mark on the scale below the *current* level of pain




Using the above scale:
What is your pain level at its best: _____ What is your pain level at its worst: _____

6. Circle all the words that describe your pain:

Intermittent Constant Deep Superficial Sharp Dull
Radiating Numb/Tingling Throbbing Burning Cold Stabbing
Other: _____

7. Which activities increase your symptoms?

Sitting Walking Kneeling Twisting Standing Reaching
Reclining Lifting Bending Stairs Rising from a Chair Squatting
Other: _____

8. What eases your symptoms? Heat Ice Medication Rest Change in position
Other _____

Name: _____

9. When is the pain worse? Morning Evening Night
Does it wake you at night? Yes No

10. Your occupation: _____

11. Are you able to keep working? Yes No Full time Part time
If yes, are you on work restriction? _____

12. Are the physical demands of your job: Light Moderate Heavy
Please describe: _____

13. Are you able to continue with recreational or home activities? Yes No
If no, please describe: _____

14. What are the goals and expectations for Physical Therapy?

_____

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***Medical information***:

15. What types of test have you had? X-ray MRI CAT Scan Bone Scan
Date of Scan: _____
Where was scan performed? _____
Results: _____

16. Please list **all** current medications: _____
_____
_____

17. Do you have any allergies? _____

18. Is there anything else you would like us to know? _____
_____

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19. (Females only): Are you Pregnant? Yes No Attempting Pregnancy? Yes No

# Patient History Form

Patient Name _____ Date _____

## Medical History

| | | | |
|---|---|---|---|
| High blood pressure | ◯ | Fracture | ◯ |
| Heart attack | ◯ | Rheumatoid arthritis | ◯ |
| Congestive heart failure | ◯ | Osteoarthritis | ◯ |
| Pacemaker | ◯ | Gout | ◯ |
| Raynaud's | ◯ | Neuropathy | ◯ |
| Asthma | ◯ | Parkinson's | ◯ |
| COPD | ◯ | Alzheimer's | ◯ |
| Stroke | ◯ | MS | ◯ |
| Vertigo/dizziness | ◯ | Fibromyalgia | ◯ |
| Seizures | ◯ | HIV | ◯ |
| Migraines | ◯ | Osteoporosis | ◯ |
| Thyroid condition | ◯ | Liver disease | ◯ |
| Diabetes | ◯ | Hepatitis | ◯ |
| Kidney disease | ◯ | Reflux | ◯ |
| Herpes | ◯ | Sleep apnea | ◯ |
| Shingles | ◯ | Bleeding disorder | ◯ |
| IBS | ◯ | Constipation | ◯ |
| Psoriasis | ◯ | Diarrhea | ◯ |
| Eczema | ◯ | Interstitial cystitis | ◯ |
| Open sores | ◯ | Prostate problems | ◯ |
| Rash | ◯ | | |

Cancer (specify right ) ◯ _____

Auto-Immune Disease _____

Do you have any other condition not listed above? No ◯ Yes _____

Do you bruise easily? Yes ◯ No ◯

Surgeries _____

_____

Notable family medical history? _____

Turn Over

## Social History

Alcohol use ◯ (type and frequency)_____

Tobacco use ◯ (type and amount per day) _____

| Have you experienced: | Yes | No |
|---|---|---|
| Anxiety | ◯ | ◯ |
| Depression | ◯ | ◯ |
| Mental Illness | ◯ | ◯ |
| Thoughts of wanting to harm yourself or others? | ◯ | ◯ |

| | Yes | No |
|---|---|---|
| Do you live alone? | ◯ | ◯ |
| Do you have good emotional support? | ◯ | ◯ |

Do you use a seat belt? Always ◯ Sometimes ◯ Never ◯

Diet? (Please Rate) Good ◯ Fair ◯ Poor ◯

Any other current life event that may impact therapy? (moving, baby, family death, job change, etc)_____

_____