FLEX physical therapy

Date:_____

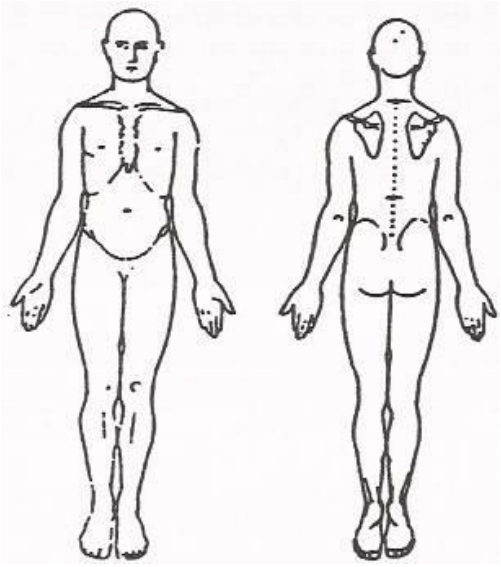
Name:_____ Age: _____

Patient Questionnaire

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

_____

_____



2. When did it start (onset)? _____

How did it start? _____

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

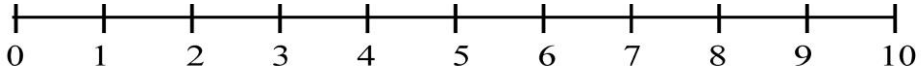
4. Have you ever had this problem, before?
If yes, (a) please describe: _____

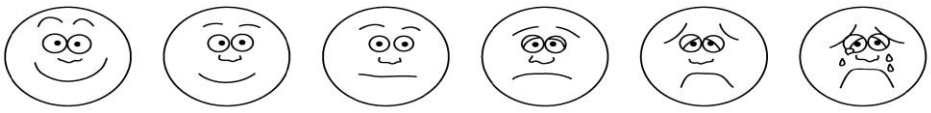
_____

(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?

_____

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?_____

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)_____

_____