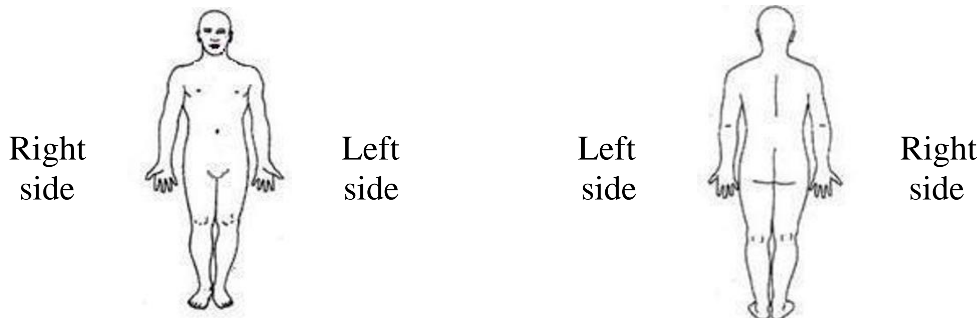
# General Patient Information

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, leave it blank and your physical therapist will assist you. Thank you.

1. What is your main complaint or problem?________________________________________
2. Do you have a history of similar episodes/complaints? ____YES ____NO
3. If yes, please explain: ________________________________________________________
4. When did this episode begin? __________________________________________________
5. How did your problem start? ___________________________________________________
6. Did you have surgery for this injury? ____YES ____NO Date of Surgery:___________
7. Please rate your pain on the scale below by circling the number(s) below:

0 1 2 3 4 5 6 7 8 9 10
no pain · mild discomfort · moderate discomfort · extreme discomfort

8. Please indicate the painful areas by shading the model:




9. Which of the following words best describes your pain?

___sharp ___dull ___burning ___throbbing
___tingling ___numb ___aching ___shooting
___variable ___constant ___radiating (moves around)

10. What positions/activities make your pain worse? ___________________________________
11. What positions/activities lessen your pain?_________________________________________
12. Does your pain ease when resting in a comfortable position? __YES ___NO
13. Does your current complaint affect your sleep? __YES ___NO

    If yes, please explain: ____________________________________________________

Patient Name ______________________________ DOB __________________________

14. List three activities that you are unable to do due to your discomfort?

1. ______________________ 2. ________________________3. ______________________

15. Check all the activities that are limited by your conditions:

| | | | |
|---|---|---|---|
| ___Walking | ___Sitting | ___Standing | ___Lifting |
| ___ Carrying | ___Sleeping | ___ Driving | ___ Bending |
| ___ Running | ___ Dressing | ___ Urinating | ___ Coughing |
| ___ Sneezing | ___ Other: ________________________ | | |

Comments: ____________________________________________________________________

______________________________________________________________________________

16. Have you been treated for this condition by any of the following?

| | | |
|---|---|---|
| __ Medical Doctor | __Osteopath | __Dentist |
| __ Psychiatrist/ Psychologist | __Physical Therapist | __Occupational Therapist |
| __Personal Trainer | __Chiropractor | Other: _______________________ |

17. Have you used any treatment at home? __YES ___NO

If yes, what kind? ____________________________________________________________

18. Are you receiving treatment for any other medical condition? __YES ___NO

If yes, please list: ____________________________________________________________

19. Have you recently taken any antibiotics? ________________________________________

20. Please list any surgeries, including elective (such as implants) that you have had:

1. ____________________________________ Reason: ________________________________

2. ____________________________________ Reason: ________________________________

21. Have you **EVER** been diagnosed with any of the following conditions?

| | |
|---|---|
| __YES ___NO Cancer | __YES ___NO Heart problems |
| __YES ___NO High Blood pressure | __YES ___NO Thyroid problems |
| __YES ___NO Circulatory problems | __YES ___NO Diabetes |
| __YES ___NO Asthma | __YES ___NO Multiple Sclerosis |
| __YES ___NO Stomach ulcers | __YES ___NO Rheumatoid arthritis |
| __YES ___NO Chemical Dependency | __YES ___NO Other arthritic conditions |
| __YES ___NO Depression | __YES ___NO Hepatitis |
| __YES ___NO Tuberculosis | __YES ___NO Stroke |
| __YES ___NO Kidney disease | __YES ___NO Blood clots |
| __YES ___NO Osteoporosis | __YES ___NO Urinary Incontinence |

Other: __________________________________

Patient Name ______________________________ DOB __________________________

22. Have you experienced any unusual symptoms?

__YES ___NO Weight loss
__YES ___NO Dizziness
__YES ___NO Fatigue
__YES ___NO Fever/Chills/Sweat
__YES ___NO Nausea vomiting
__YES ___NO Headaches
__YES ___NO Weakness
__YES ___NO Numbness tingling

23. Allergies: Latex: __YES ___NO Medications:___________________________________
Other:___________________________________________________________________

24. Please list any physician prescribed medication you are currently taking:

1.____________________________________ Reason: ________________________________
2.____________________________________ Reason: ________________________________
3.____________________________________ Reason: ________________________________
4.____________________________________ Reason: ________________________________

25. Please list any non- prescribed medication you are currently taking:

1.____________________________________ Reason: ________________________________
2.____________________________________ Reason: ________________________________
3.____________________________________ Reason: ________________________________
4.____________________________________ Reason: ________________________________

26. Self-Assessment: Please check 1-10 (10 being extremely high)

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Quality of life | | | | | | | | | | | Overall Health | | | | | | | | | | |
| Energy level | | | | | | | | | | | Nutritional Habits | | | | | | | | | | |
| Physical strength | | | | | | | | | | | Physical Appearance | | | | | | | | | | |
| Physical endurance | | | | | | | | | | | Flexibility | | | | | | | | | | |
| Aerobic endurance | | | | | | | | | | | Agility- balance coordination | | | | | | | | | | |

1. Are you currently working outside of the home? __YES ___NO
2. Please write your occupation and describe the physical demands involved:

_________________________________________________________________________

3. Please expand on any other physical activities that you are involved in:

_________________________________________________________________________

4. Do you have children? __YES ___NO How many? ____________________________

Patient Name ________________________________ DOB ____________________________

5. Social History:

Tobacco use: ___ per day Caffeine use: ___ per day

Alcohol use: ___per day Recreational drugs: ___ per day

6. What is your average level of stress 1-10? (10 being extremely high) _______________

7. What decreases your stress? ________________________________________________What are your goals/expectations from therapy?

___ Relieve pain ___Return to work ___Increase range of motion

___ Return to sports ___ Return to recreational activities

Other: _________________________________________________________________

8. What would be your barriers to achieving your goals?

___ Pain ___Low energy ___Lack of support

___Procrastination ___ Lack of motivation ___ Too many commitments

___Dislike exercise Other: ________________________________________________

Thank you for taking the time to fill out this questionnaire, we are committed to providing the best possible care to maximize your results.

**Patient Signature: ________________________________ Date: _____________________**