# Physical Therapy Patient Questionnaire

1. **With whom do you live?**
   - [ ] Alone
   - [ ] Sitter
   - [ ] Spouse
   - [ ] Family
   - [ ] Patient is primary care giver
   - [ ] Other

2. **Employment/Work**
   - [ ] Working full-time
   - [ ] Working part-time
   - [ ] Retired
   - [ ] Unemployed
   - [ ] Student
   - [ ] Work from home
   - Occupation: ________________________________

3. **Dwelling:**
   - [ ] House
   - [ ] Assisted Living
   - [ ] Apartment
   - [ ] Wheelchair
   - [ ] Walker
   - [ ] Cane
   - Equipment used: ________________________________

4. **Do you have:**
   - [ ] Stairs to climb
   - [ ] Goggles, hearing aids
   - [ ] Railing
   - [ ] Assisted devices for bathing/dressing
   - [ ] Uneven terrain
   - Other: ________________________________

5. **Functional Status/Activity Level**
   - Difficulty with:
     - [ ] Bed mobility
     - [ ] Transfers (moving from bed to chair/bathroom)
     - [ ] Difficulty walking
     - Problem areas: [ ] level ground
     - [ ] on stairs
     - [ ] ramps
     - [ ] uneven terrain
     - [ ] Difficulty with self care (bathing, dressing, eating, toileting)
     - [ ] Difficulty with home management (household chores, shopping, gardening, driving, care of dependent)
     - [ ] Difficulty with community and work activities/integration
     - [ ] Work/school
     - [ ] Recreation or play activities

6. **If student, school you are currently attending:**
   - ___________________________________________________

## Current Condition / Chief Complaint

7. **Describe the problem for which you seek therapy**
   - ___________________________________________________

   When did the problem begin (date)?
   - Month __________________________
   - Year ____________________

   What happened:
   - ___________________________________________________

   Have you ever had this problem before?  [ ] Yes  [ ] No

   If yes, what did you do for the problem?
   - ___________________________________________________

   Is this the result of a car accident? If yes, describe the accident
   - ___________________________________________________

8. **When is it the worst?**
   - [ ] Morning
   - [ ] Evening
   - [ ] Constant
   - [ ] Standing
   - [ ] Sitting
   - [ ] Walking
   - [ ] Driving
   - [ ] Other

   How are you taking care of the problem now?
   - ___________________________________________________

   What makes the problem better?
   - ___________________________________________________

   What makes the problem worse?
   - ___________________________________________________

9. **What procedures have you had for this problem?**
   - Check all that apply
   - [ ] Xray
   - [ ] MRI
   - [ ] CT
   - [ ] Injections/blocks
   - [ ] Surgery
   - [ ] Other
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10. Please shade on the diagram below the location of your problem/pain.

Describe your pain
- Sharp
- Dull
- Aching
- Shooting
- Throbbing
- Other ___________________

Is your pain
- Constant
- Intermittent
- Variable

11. Pain Rating: Please rate your pain using the numeric scale listed below.

A rating of “0” means you have no pain at all.
A rating of “10” means that your pain is unbearable and you should go to the Emergency Room immediately.

PLEASE RATE YOUR PAIN AT THE PRESENT TIME
0 1 2 3 4 5 6 7 8 9 10
No Pain Moderate Pain Intense Pain – Go to ER

PLEASE RATE YOUR PAIN AT IT’S WORST IN THE LAST 2 WEEKS
0 1 2 3 4 5 6 7 8 9 10
No Pain Moderate Pain Intense Pain – Go to ER

12. What are your goals for therapy? (Check all that apply)
- Reduce Pain to ___/10
- Increase Function
- Improve Posture
- Improve Flexibility
- Increase Strength
- Prevent surgery
- Walk unassisted
- Prepare for surgery
- Return to full activities
- Increase stability
- Improve Balance
- Increase endurance
- Other ____________________________________________________________________________

13. What activities are you not performing because of your current problem/pain?
- Vacuums
- Making the beds
- Laundry
- Golf
- Driving
- Bathing/Dressing
- Cleaning
- Dancing
- Gardening
- Carrying Groceries
- Using hands
- Shopping
- Cooking
- Lifting 10 lbs.
- Tennis
- Walking longer than a block
- Other ____________________________________________________________________________
### Physical Therapy Patient Questionnaire

**Medical History** (Please check all that apply)

- [ ] Coronary heart disease
- [ ] Irregular heart beat
- [ ] High blood pressure
- [ ] Cancer – Type: ______
- [ ] Lung Disease (COPD, Asthma, Emphysema…..) – Type ____________________________
- [ ] Arthritis -- Type: ______
- [ ] Where: ____________________________
- [ ] Osteoporosis
- [ ] Fracture related to Osteoporosis (wrist, spine, hip, etc.)
- [ ] Surgery in the last 12 months - Body part: ______ When ______
- [ ] Any chronic illness or condition – What type? ____________________________
- [ ] Allergies – Please list ____________________________
- [ ] Hernia (or any condition which can be aggravated with lifting)
- [ ] Current smoker
- [ ] Former smoker
- [ ] Pregnant / Possibly pregnant
- [ ] Memory Loss / Alzheimer’s / Dementia
- [ ] Problems with swelling Location: ______
- [ ] Previous Broken Bones Location: ______
- [ ] Balance Disorder
- [ ] Vertigo
- [ ] Depression
- [ ] Other – Please List ____________________________

Please list any medications that you are taking for the above conditions or your current injury:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

14. We occasionally have Physical Therapy Interns who perform clinical rotations at our facility. These individuals will be working with the therapist that is treating you. Do you agree to allow an intern participate in your sessions?  
- [ ] Yes  
- [ ] No

15. In the event that we recommend continued exercise in the Fitness, Wellness Center or Spa, I hereby authorize One Nineteen Physical Therapy to release copies of my Medical Record to these services on a need to know basis.  
- [ ] Yes  
- [ ] No

Thank you for choosing One Nineteen Health and Wellness for your physical therapy needs!

Patient’s Signature __________________ Date __________________

Therapist Signature __________________ Date __________________