Patient Questionnaire

owens physical therapy specialists

Patient Name: _____
Date of Birth _____ **Current Age** _____
Height _____ **Weight** _____

Please fill out both sides completely and accurately

CURRENT MEDICAL CONDITION

Please describe relevant symptoms: _____

_____

Date symptoms began: _____
Symptoms are (check one): □ Improving □ Unchanging □ Worsening
□ Constant (where?_____) □ Intermittent (where?_____)
Symptoms began □ as a result of _____ □ for no apparent reason

Please check the words that best describe your symptoms/pain:

□ Sharp	□ Prickly	□ Popping	□ Dull	□ Spasms	□ Catching	□ Burning
□ Fatigue	□ Stiff	□ Aching	□ Tingling	□ Weakness	□ Numbness	□ Other: _____

Please rate your pain on a scale of 0-10 (0 being no pain; 10 being the worst pain imaginable)
Currently _____ At Best _____ At Worst _____

Symptoms are **worse** when you: (circle as applicable to you)

bend	sit or rise	stand
walk	lie down	cough/sneeze/strain
in AM	as day progresses	in PM
when still	when on the move	
use heat	use cold	

Symptoms are **better** when you:

bend	sit or rise	stand
walk	lie down	
in AM	as day progresses	in PM
when still	when on the move	
use heat	use cold	take medication

REGARDING THIS CONDITION:

Previous occurrences of this problem: □ 0 □ 1-5 □ 6-10 □ 11+ Year problem first occurred: _____
Previous history: _____
Previous treatments: _____ Previous surgeries: _____ Date:_____
Tests/Procedures: □ X-rays □ MRI □ Myelogram □ EMG/nerve conduction study □ injections

What activities are difficult because of this condition? PLEASE ELABORATE AS NECESSARY

□ Sitting:
□ Standing:
□ Walking:
□ Sleeping:
□ Driving:
□ Lifting:
□ Grooming/bathing/dressing:
□ In/out of bed or chairs:
□ Stairs:
□ Yardwork:
□ Housework:
□ Other:

(OVER)

WORK HISTORY

Are you currently employed? □ Yes □ No □ Retired □ Student
If yes, occupation: _____ Brief job description: _____
Who is your employer? _____
Currently working: □ Full time □ Part time □ Working w/ restrictions □ Not working because: _____
Postures/stressors at work: _____How long have you had this job? _____
Are you off work because of your current problem? □ No □ Yes, since _____
Restrictions your physician has placed on your work/activities: _____

GENERAL HEALTH HISTORY

Please check all that apply to your medical history.

□ Arthritis
□ Asthma/emphysema
□ Bowel problems (recent?)
□ Cancer/tumors
□ Chest pains/angina
□ Diabetes/hypoglycemia
□ Fractures
□ Gynecological problems
□ Head injury
□ Heart/cardiac history
□ High/low blood pressure
□ Kidney/bladder problems (recent?)
□ Nerves/anxiety/emotional distress
□ Osteoporosis
□ Pacemaker
□ Peripheral vascular disease
□ Seizures
□ Sleeping disorders
□ Stroke/TIA
□ Thyroid
□ Ulcers
□ Weight gain/loss
□ Smoking _____ packs/day
□ Other: _____

List any medications you are taking FOR THIS CONDITION: _____
FOR GENERAL HEALTH: _____

Please list ANY allergies you have (including latex): _____

Please list recent or major surgeries you have had: _____
Are you □ Right handed □ Left handed

Do you wear corrective lenses? □ Yes □ No
Do you wear hearing aides? □ Yes □ No

Do you live alone? □ Yes □ No Is there someone who would help you if needed? □ Yes □ No

How do you best learn? (check all that apply)
□ Demonstration □ Explanation □ One-on-one □ Printed material

For women: Are you pregnant? □ Yes □ No Have you had a bone density test? □ Yes □ No

How did you hear about us? _____

What is your goal for treatment? _____

The above information is complete and correct.

Patient signature _____**Date**_____

Additional therapist comments: _____
_____

Therapist signature: _____Date_____
Therapist should also initial all areas where side comments were added