FLEX physical therapy

Date:____________________

Name:____ Age: ______________

Patient Questionnaire

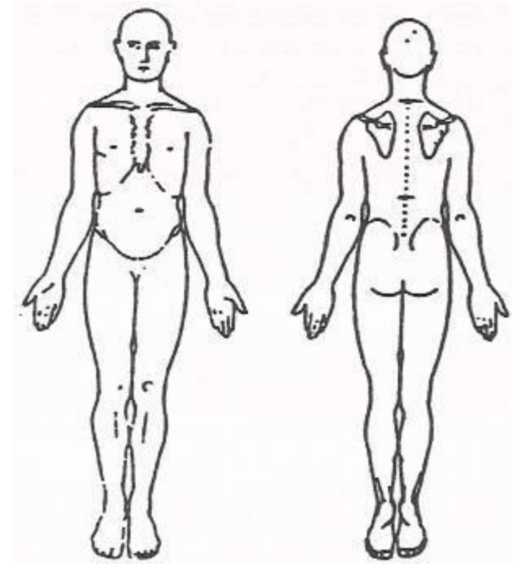
1. Describe the problem that brought you to physical therapy:

____

____

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

0----1----2----3----4----5----6----7----8----9----10

0=No pain 10=Needs emergency

Using the above scale:

What is your pain level at its best: ________ What is your pain level at its worst: _______

Percent of time pain is experienced □ 0-25% □ 26-50% □ 51-75% □ 76-100%

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

	Current	Past		Current	Past
High Blood Pressure	◯	◯	Fracture	◯	◯
Heart Attack	◯	◯	Rheumatoid arthritis	◯	◯
Congestive heart failure	◯	◯	Osteoarthritis	◯	◯
Pacemaker	◯	◯	Gout	◯	◯
Raynauds	◯	◯	Neuropathy	◯	◯
Asthma	◯	◯	Parkinsons	◯	◯
COPD	◯	◯	Alzeheimers	◯	◯
Stroke	◯	◯	MS	◯	◯
Vertigo/Dizziness	◯	◯	Fibromyalgia	◯	◯
Seizures	◯	◯	HIV	◯	◯
Migraines	◯	◯	Osteoperosis	◯	◯
Thyroid Disease	◯	◯	Liver Disease	◯	◯
Diabetes	◯	◯	Hepatitis	◯	◯
Kidney Disease	◯	◯	Reflux	◯	◯
Herpes	◯	◯	Leukemia	◯	◯
Shingles	◯	◯	Bleeding Disorder	◯	◯
IBS	◯	◯	Constipation	◯	◯
Psoriasis	◯	◯	Diarrhea	◯	◯
Eczema	◯	◯	Interstitial Cystitis	◯	◯
Open sores	◯	◯	Prostate problems	◯	◯
Rash	◯	◯			

	Current	Past	
Cancer (specify right)	◯	◯	________________________________

Auto-Immune Disease ____

Have you had any serious illness not listed above? No ◯ Yes ________________________

Do you bruise easily? Yes ◯ No ◯

Surgeries____

____

Noteable family medical history?____

Turn Over

Social History

	Current	Past	
Alcohol use	◯	◯	(type and frequency)______________________________
Tobacco use	◯	◯	(type and ammount per day) ______________________________
Have you experienced:			
Anxiety	◯	◯	
Depression	◯	◯	
Bipolar	◯	◯	
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)____________________________

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