Baldwin Bone and Joint

Physical Therapy Questionnaire

Date: _____/_____/_____ DOB: _____/_____/_____

Name:

_____

_

Height: _____ Weight: _____ Are you currently working? Yes/No

Employer: _____ Occupation:

_____

Have you received any Physical, Occupational, or Speech Therapy this year?

_____

_____

Have you had any falls in the past 12 months?

_____

Part of body being treated:

_____

When did this problem begin?

_____

Was this an injury or an accident?

_____

How did this problem begin?

_____

Have you received any of the following treatments for this problem? (Circle all that apply)

Epidural Medication Exercise Physical Therapy

Chiropractic Bracing Surgery
Other:_____

Have you had any of the following: (Circle all that apply)

MRI CT Scan X-ray NCV
Other:_____

List any prescription and over-the-counter medications that you are currently taking (provide copy of list if available):

_____
_____
_____
_____
_____
_____

Do you have a history of any of the following: (Circle all that apply)

Diabetes Gout Depression

Heart Problems High Blood Pressure Joint Injuries

Pacemaker Arthritis Stroke

Liver/Kidney Disease Seizures Asthma

Dizziness/Fainting Cancer (please explain)_____

Allergies including latex or tape allergy (please explain):

_____

Other:

_____
__

Please indicate your pain rating on the scale below (rate 1 to 10):

0____1_____2_____3_____4_____5_____6_____7_____8_____9____10

No Pain Moderate Pain Extreme Agony

Circle any of the following that describes your pain:

Sharp	Dull	Burning	Aching	Tingling
Numb	Constant	Variable	Radiating	Shooting

What makes your pain better?

_____

What makes your pain worse?

_____

Please indicate painful areas by shading the diagrams below: