Baldwin Bone and Joint

Physical Therapy Questionnaire

Name: _____ **Date:** _____/_____/_____

DOB: _____/_____/_____ **Height:** _____ **Weight:** _____

Are you currently working? Yes/No **Retired?** Yes/No

Employer: _____ **Occupation:** _____

Disabled? Yes/No **If yes, reason for disability:** _____

Have you received any Physical/Occupational/Speech Therapy this year? Yes/No

Have you received any home health services in the past month? Yes/No

Are you currently receiving home health services, including therapy, nursing, or aid services? Yes/No

Have you had any falls in the past 12 months? Yes/No

If yes, how many? _____

If yes, did you receive an injury as a result of fall(s)? Yes/No

If yes, please explain_____

Part of body being treated: _____

When did this problem begin? _____ **Was this the result of an injury?** Yes/No

How did this problem begin? _____

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

Epidural Medication Exercise Physical Therapy

Chiropractic Bracing Surgery Other:_____

Have you had any of the following for this problem: (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)_____	

Please list past surgeries:_____

Other Medical History: _____

Any allergies (including drug allergies, latex or tape allergies). Please explain:

_____

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 for current problem by shading the diagrams below: