



**PIC PHYSICAL THERAPY  
QUESTIONNAIRE**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_

SS#: \_\_\_\_\_ Company Name: \_\_\_\_\_

Are you presently off work? Yes \_\_\_ No \_\_\_ If so, how long has it been? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**MEDICAL HISTORY:** Have you experienced any of the following?

\_\_\_ Currently Pregnant

\_\_\_ Current Fracture

\_\_\_ Heart Problems

\_\_\_ Diabetes/Hypoglycemia

\_\_\_ Loss of Sensation

\_\_\_ High Blood Pressure

\_\_\_ Respiratory Disorder (Asthma, Etc.)

\_\_\_ Metal or Plastic Implant

\_\_\_ Surgery

\_\_\_ Seizure Disorder

\_\_\_ Vision or Hearing Problems

\_\_\_ Tumor/Cancer

\_\_\_ HIV/AIDS

If you checked any of the above, please explain: \_\_\_\_\_

Are you allergic to anything? \_\_\_\_\_

What tests have you had?

\_\_\_ X-rays Date: \_\_\_\_\_

\_\_\_ MRI Date: \_\_\_\_\_

\_\_\_ CT Scan Date: \_\_\_\_\_

\_\_\_ EMG Date: \_\_\_\_\_

\_\_\_ Arthrogram Date: \_\_\_\_\_

Please list any previous surgeries and dates \_\_\_\_\_

What type of exercise do you do?

\_\_\_ Strenuous \_\_\_ Moderate \_\_\_ Light \_\_\_ None

**PAIN HISTORY:**

Using a scale from 0-10 (10 being the worst), how would you rate your pain?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

How often do you experience your symptoms?

\_\_\_ Constantly (76-100% of the time) \_\_\_ Frequently (51-75% of the time)

\_\_\_ Occasionally (26-50% of the time) \_\_\_ Intermittently (1-25% of the time)

How often do you experience numbness/tingling?

- Constantly (76-100% of the time)  Frequently (51-75% of the time)  
 Occasionally (26-50% of the time)  Intermittently (1-25% of the time)  
 Never (0% of the time)

How much has the problem interfered with your work?

- Not at all  A little bit  Moderately  Quite a bit  Extremely

How much has the problem interfered with your home/social activities?

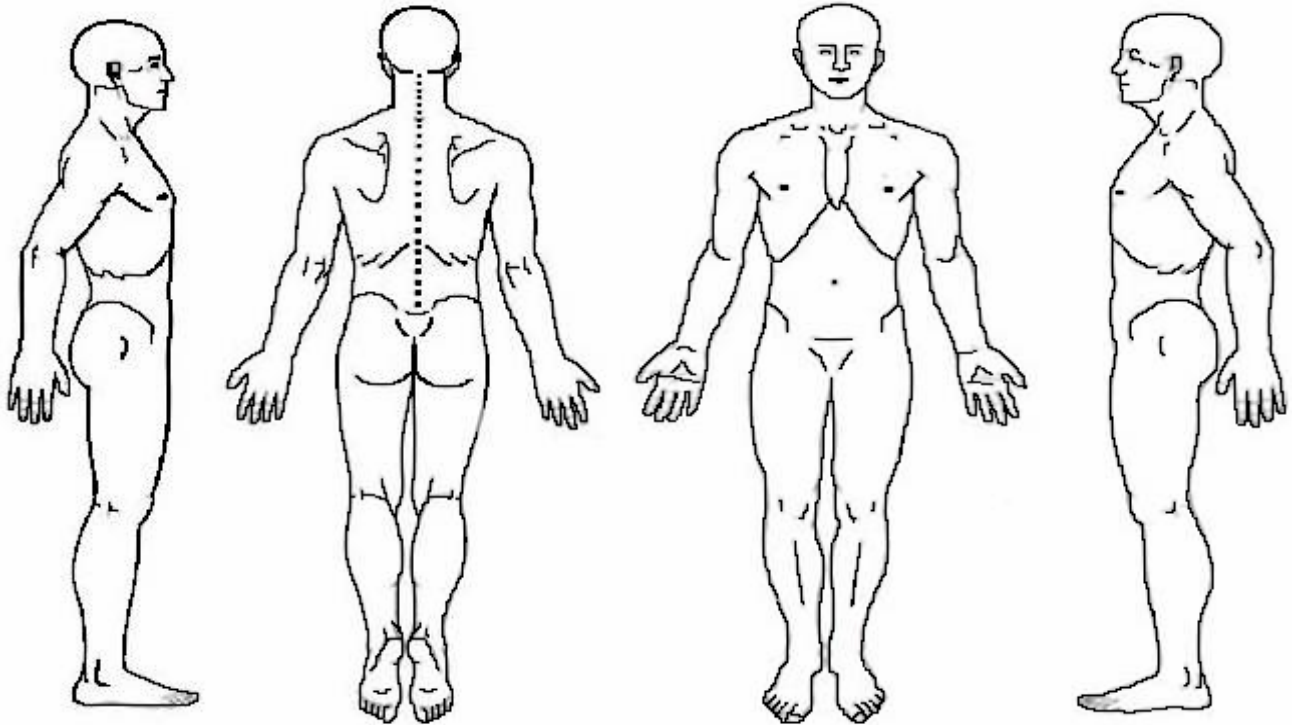
- Not at all  A little bit  Moderately  Quite a bit  Extremely

What aggravates your problem? \_\_\_\_\_

What concerns you the most about your problem; what does it prevent you from doing?  
\_\_\_\_\_  
\_\_\_\_\_

Circle the areas on the figure below where you feel pain today.

Use "X" marks to show where you feel numbness & tingling/pins & needles.



I authorize the treatment and procedures that will be performed by the Physical Therapy Staff.

Signed \_\_\_\_\_ Date: \_\_\_\_\_