

**PHYSICAL THERAPY PLUS
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?

<input type="checkbox"/> Currently Pregnant	<input type="checkbox"/> Current Fracture
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Diabetes/Hypoglycemia
<input type="checkbox"/> Loss of Sensation	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Respiratory Disorder (Asthma, Etc.)	<input type="checkbox"/> Metal or Plastic Implant
<input type="checkbox"/> Surgery	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Vision or Hearing Problems	<input type="checkbox"/> Tumor/Cancer
<input type="checkbox"/> HIV/AIDS	

If you checked any of the above, please explain: _____

Are you allergic to anything? _____

What tests have you had?

<input type="checkbox"/> X-rays	Date: _____
<input type="checkbox"/> MRI	Date: _____
<input type="checkbox"/> CT Scan	Date: _____
<input type="checkbox"/> EMG	Date: _____
<input type="checkbox"/> 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?

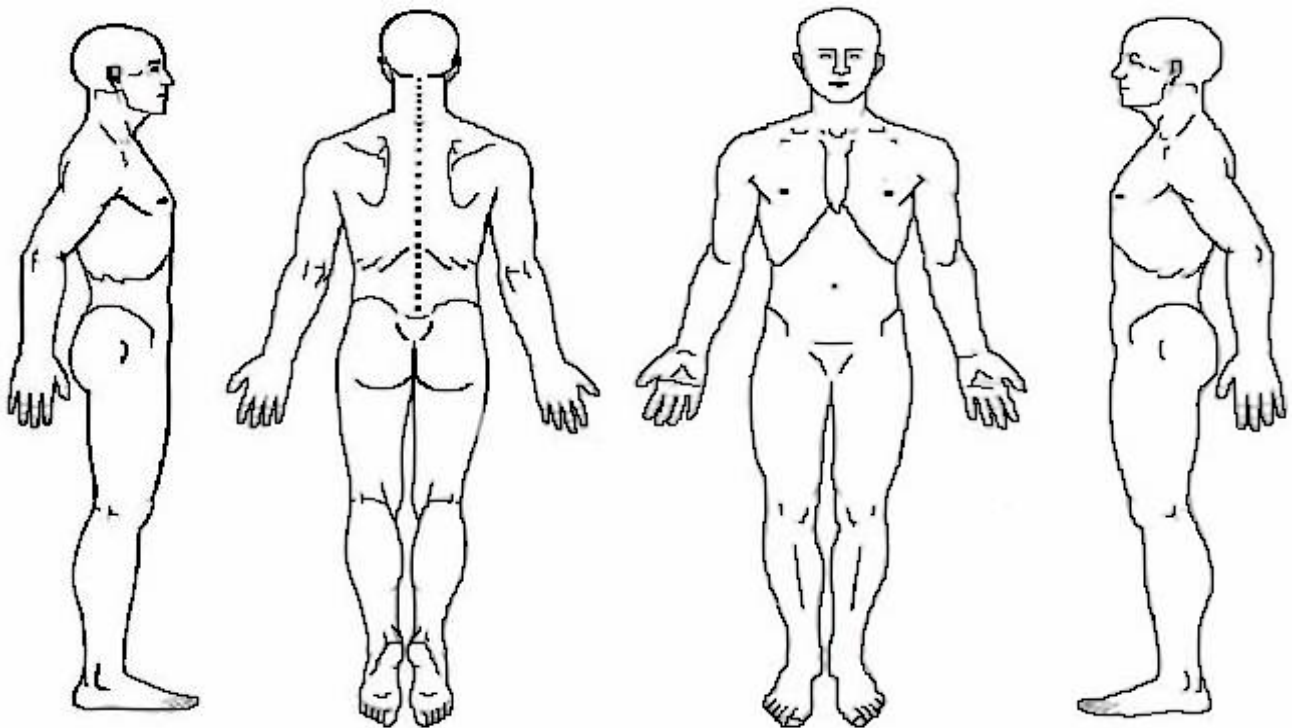
- Not at all A little bit Moderately Quite a bit Extremely

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 _____