



PATIENT INITIAL QUESTIONNAIRE

NAME: _____

DATE: _____

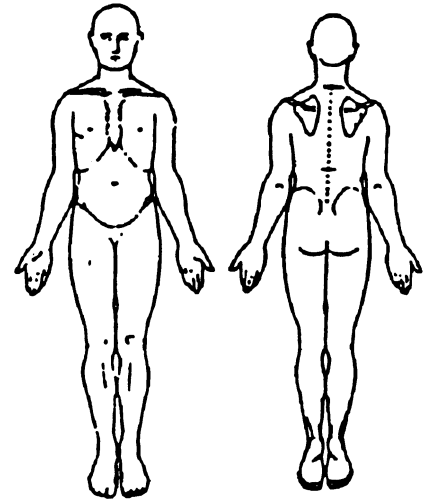
This form contains a series of questions designed to help your clinician evaluate your condition, track how you feel, and determine how well you are able to do your usual activities. This information will help your therapist and referring physician give you the best possible care. Please answer every question as accurately and completely as you can.

1. What are your symptoms/chief complaint? _____
 Indicate areas of pain or abnormal sensation on the body diagram below

2. Which of the following best describes how your injury occurred?
 lifting trauma cumulative trauma/overuse _____
 MVA (car accident) degenerative process a fall
 during recreation/sports unknown/gradual onset Other: _____

3. Where did your injury occur? at work auto personal home other premise (please specify _____)
 N/A due to gradual onset

4. Date of Injury/Onset of Pain: Month _____ Day _____ Year _____



5. Nature of Symptoms (Check all that apply) sharp aching
 tingling dull occasional numbness throbbing
 constant Other: _____

6. Please indicate your pain level on a scale of 0 to 10 _____
 (0 = no pain, 1,2,3 = low pain, 4,5,6 = moderate pain, 7,8,9 = intense pain, 10 = emergency)

7. Have you ever had an operation on the body region associated with your current symptoms? No Yes, Date/Type _____

8. Do your symptoms wake you up at night?
 No Yes/Frequency? _____
 If yes, is it present
 While lying still? Only when changing positions? Both?

9. Are your symptoms worse in the: Morning Evening Neither

10. What aggravates your symptoms? (Check all that apply)

<input type="checkbox"/> sitting _____	<input type="checkbox"/> reaching overhead	<input type="checkbox"/> coughing/sneezing
<input type="checkbox"/> going to/rising from sitting	<input type="checkbox"/> reaching out from body	<input type="checkbox"/> taking a deep breath
<input type="checkbox"/> standing _____	<input type="checkbox"/> reaching behind back	<input type="checkbox"/> sleeping
<input type="checkbox"/> kneeling/squatting _____	<input type="checkbox"/> reaching across body	<input type="checkbox"/> looking up overhead
<input type="checkbox"/> lying _____	<input type="checkbox"/> sustained bending	<input type="checkbox"/> swallowing
<input type="checkbox"/> walking _____	<input type="checkbox"/> recreation/sports including _____	<input type="checkbox"/> stress
<input type="checkbox"/> up/down stairs _____	<input type="checkbox"/> household activities including _____	<input type="checkbox"/> driving
<input type="checkbox"/> repetitive activities including (gripping, typing, reaching, etc) _____	<input type="checkbox"/> other: _____	<input type="checkbox"/> getting dressed _____
<input type="checkbox"/> lifting _____		<input type="checkbox"/> other: _____

Please complete other side

11. Please list any activities that you can't do now as a result of your current injury/symptoms: _____

12. What relieves your symptoms? (Check all that apply)

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> sitting | <input type="checkbox"/> exercise | <input type="checkbox"/> traction |
| <input type="checkbox"/> changing positions | <input type="checkbox"/> rest | <input type="checkbox"/> whirlpool |
| <input type="checkbox"/> standing | <input type="checkbox"/> cold | <input type="checkbox"/> medication |
| <input type="checkbox"/> lying | <input type="checkbox"/> heat | <input type="checkbox"/> alcohol |
| <input type="checkbox"/> walking | <input type="checkbox"/> massage | <input type="checkbox"/> nothing |
| <input type="checkbox"/> stretching | <input type="checkbox"/> splinting/brace wear | <input type="checkbox"/> Other: _____ |

13. What previous treatment have you had related to your injury? (Check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> none | <input type="checkbox"/> bracing/taping | <input type="checkbox"/> TENS unit |
| <input type="checkbox"/> medication (oral) | <input type="checkbox"/> traction | <input type="checkbox"/> massage therapy |
| <input type="checkbox"/> physical/occupational therapy | <input type="checkbox"/> injection into the spine | <input type="checkbox"/> IME |
| <input type="checkbox"/> Chiropractic/Osteopathic | <input type="checkbox"/> injection into the skin/muscles | |

14. Have you had any of the following tests for current condition? Arthrogram PCE CT Scan
 X-rays MRI Other _____
Results? _____

15. Do you exercise on a regular basis? Yes No

16. Do you have access to exercise equipment/pool facilities? Yes No

17. What goals would you like to achieve from therapy? _____

Please indicate if you have had or currently have the following medical conditions: UNREMARKABLE

- | | | |
|---|---|--|
| <input type="checkbox"/> cancer | <input type="checkbox"/> heart disease | <input type="checkbox"/> pacemaker |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> diabetes | <input type="checkbox"/> no medications |
| <input type="checkbox"/> pregnant-currently | <input type="checkbox"/> bone/joint disorder/injury | <input type="checkbox"/> medications (please list) _____ |
| <input type="checkbox"/> bowel/bladder problems | <input type="checkbox"/> history of seizures | _____ |
| <input type="checkbox"/> joint replacement | <input type="checkbox"/> breathing difficulties | _____ |

WORK HISTORY: Are you currently working? Yes, normal duty Yes, restricted duty No Retired
Occupation (be specific): _____ Normal work schedule: _____
Briefly describe your job duties: _____

If you were injured on the job or work is affected by your current symptoms, please fill out questions 18 to 21

18. Last day of full duty? _____ Is light duty available? Yes No
19. What positions are you in while working? (check all that apply) Indicate frequency: **S**/Seldom, **O**/Occasional, **F**/Frequent
 Sitting _____ Standing _____ Walking _____ Bending _____ Push/Pull _____ Kneeling/Squatting _____
 Forward Reaching _____ Overhead Reaching _____ Repetitive grasp/pinch _____ Climbing (ladders/stairs, etc) _____
20. Max. weight carried (lbs): _____ Distance: _____
Max weight lifted from floor: _____ From knee to shoulder height: _____ Overhead: _____
21. Return to work goal: Job of Injury: Yes No Other _____

Therapist Signature: _____ Date: _____