TheraPhysical

PRE-EXAM QUESTIONNAIRE
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PATIENT INFO

Last Name _____ First Name:_____ Age___ Male____ Female___

Occupation_____ Phone #: _____

IN ORDER TO EVALUATE YOUR CONDITION FULLY, PLEASE BE AS ACCURATE AS POSSIBLE

1. Have you had physical therapy before? No____ Yes ____; When_____
2. Have you had Home Health Care? No____ Yes ____; When_____
3. Where is your pain/injury? _____
4. What caused your pain/injury? _____
5. Approximately when did the pain/injury start? _____
6. Is the pain/injury getting? Worse_____ Better _____ Staying the Same _____
7. Have you ever had this pain/injury before? No ____ Yes____ When _____
8. Is your pain? Constant (never goes away) _____ Intermittent (comes & goes) _____
9. On a scale from zero to ten, circle your worse pain level in the past couple of days

   0 1 2 3 4 5 6 7 8 9 10
10. Are you taking any medication for this pain/injury? No ___ Yes ___What kind, does it help _____
11. Are any of your usual everyday activities affected? No ____ Yes ____ Describe how _____

    _____
12. List all past surgeries with dates _____

    _____
13. List all medical conditions you have _____

    _____
14. Other important information we should know about _____

Patient Signature _____ **Date** _____

INITIAL EVALUATION

Physical Therapist _____ **Initials** _____ **Date** _____