Mountain2City Physical Therapy

Patient Questionnaire

Name_____ Date_____

What is your reason for coming to therapy? _____

Describe your symptoms:

Where? _____

What does it feel like? (sharp, achey, etc) _____

When does it happen? _____

When did it start? _____

Was there an injury or activity that caused the symptoms? _____

What makes it feel better? _____

What makes it feel worse? _____

Does it get better or worse as the day progresses? _____

Overall are you getting better, worse or not changing? _____

Have you had similar problems in the past? _____

Are your symptoms constant or intermittent? _____

Does pain wake you up at night? _____ Preferred sleep position: _____

Have you experienced any of the following medical symptoms? Check all that apply.

___Bladder or bowel dysfunction	___Generalized weakness	___Fever/chills
___Unexplained weight loss or gain	___Genital numbness	___Night pain/Sweats
___Numbness	___ Dizziness	___Vision Disturbance
___Changes in hearing	___Fainting or Falls (how many)? _____	

Have you had diagnostic tests? (X-ray, MRI, etc) ____ Results? _____

Where? _____

Any other treatments for this condition? (massage, chiropractic, etc) _____

Surgery (date, type) _____

Any other surgeries? _____

Are you currently working? _____ Occupation _____

Fall history: Have you fallen in the last 12 months? _____

Are you worried that you might fall? _____

Do you feel unsteady on your feet or that your balance is impaired? _____

Medications: _____

_____

Do you have any of the following medical conditions?

___Cancer ___High blood pressure ___Heart Disease ___Pacemaker
___History of Seizures ___Diabetes ___Osteoporosis
___Bone/ Joint disorders ___Joint Replacement ___Breathing Difficulties
___Latex Allergy ___Currently Pregnant ___Other: _____

Do you exercise regularly? _____ Activities you do for exercise/recreation _____

What are your goals for physical therapy treatment? (i.e. What are you currently limited from doing because of your symptoms?) _____

_____

03/17