

Patient Questionnaire

Have you been seen for physical therapy at another clinic since January 2008? YES NO

If yes, what clinic were you seen at _____ # of visits _____

What is your preferred name: _____

How and when did your injury or pain start? _____

What are your current symptoms? _____

Are you taking medications? _____

Do you have any medical problems and/or have you had any previous injuries or surgeries? _____

Do you have any allergies? _____

Do you, or have you had any of the following?

	Yes	No
1. Pacemaker	_____	_____
2. Are you pregnant?	_____	_____
3. Joint replacement	_____	_____
4. Plastic or metal implants	_____	_____
5. Cancer/Tumor	_____	_____
6. Increased/decreased sensation to heat/cold	_____	_____
7. Circulatory or vascular problems	_____	_____
8. History of respiratory (breathing) dysfunction	_____	_____
9. Dermatologic (skin) conditions	_____	_____

Indicate on the bodies where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

/// Stabbing

XXX Burning

OOO Pins and needles

--- Numbness

