

Questionnaire

Why were you referred to Physical Therapy by your physician? _____

How long have you had this problem? _____

When did this problem start? _____

Have you had similar problems in the past? Yes No If yes, when? _____

Is your problem related to an injury? Yes No

How did your problem start or where and how did the injury happen? _____

What treatment have you previously received for this problem?

Physical Therapy Occupational Therapy Chiropractic Care Bed Rest

Surgery Medications _____

Other _____

What test have you received for this problem?

Bone Scan X-Rays MRI Scan

When _____ When _____ When _____

CAT Scan EMG/NCV Myelogram

When _____ When _____ When _____

Please rate your current ability to function with your everyday activities as a result of your problem or injury.

0% 25% 50% 75% 100%

Check all the activities that you have trouble performing as a result of your present condition.

Bathing Child Care Dressing Eating

Homemaking Sexual Intercourse Sitting Sleeping

Standing Walking Working Yard Work



How long can you tolerate the following?

	<i>Less than 30 minutes</i>	<i>1 - 2 Hours</i>	<i>3 - 4 Hours</i>	<i>No Problems</i>
Walking	___	___	___	___
Sitting	___	___	___	___
Standing	___	___	___	___

Occupation: _____

Hobbies: _____

Job Demands:

Lifting/Carrying

___ 10 lbs. or Less ___ 10 - 15 lbs. or Less ___ 15 - 25 lbs. ___ 25 - 50 lbs. ___ 50 or More lbs.

Frequency

___ 1 Hour or Less ___ 1 - 2 Hours ___ 2 - 4 Hours ___ 4 - 6 Hours ___ 6 or More Hours

Repetitive Arm Use

___ 1 Hour or Less ___ 1 - 2 Hours ___ 2 - 4 Hours ___ 4 - 6 Hours ___ 6 or More Hours

Sitting

___ 1 Hour or Less ___ 1 - 2 Hours ___ 2 - 4 Hours ___ 4 - 6 Hours ___ 6 or More Hours

Standing

___ 1 Hour or Less ___ 1 - 2 Hours ___ 2 - 4 Hours ___ 4 - 6 Hours ___ 6 or More Hours

Walking

___ 1 Hour or Less ___ 1 - 2 Hours ___ 2 - 4 Hours ___ 4 - 6 Hours ___ 6 or More Hours

At this time are you working: ___ Full Time ___ Light Duty ___ Part Time ___ Off Work

Please place a mark through the line below to identify the severity of your pain

At Rest	<i>No Pain</i>	1	2	3	4	5	6	7	8	9	10	<i>Most Severe Pain</i>
With Activity	<i>No Pain</i>	1	2	3	4	5	6	7	8	9	10	<i>Most Severe Pain</i>

Describe Your Pain

___ Constant	___ Comes and Goes	___ Dull Ache	___ Sharp
___ Burning	___ Throbbing	___ Shooting	
___ Worse in Morning	___ Worse in Afternoon	___ Worse at Night	___ Other

