

Patient Name: _____

Date: _____

Referring Physician: _____

Dominance: Right Handed Left Handed Ambidextrous

PHYSICAL THERAPY NEW PATIENT QUESTIONNAIRE

What is your PRIMARY reason/diagnosis for coming to physical therapy today: _____

When did this problem begin? _____

Date of most recent episode: _____

Which of the following best describes how the pain/injury began (Check all that apply and date, if applicable)

Accident/Injury at home Injury at work Work related/Repetitive Stress Motor Vehicle Accident

After surgery After illness "Just began" Came on gradually Other: _____

If Accident, please describe: _____

Other factors, problems or injuries that are contributing or affecting your current pain/problem. _____

Current General Health: Excellent Good Fair Poor Previous General Health: Excellent Good Fair Poor

Comments: _____

How would you best describe your pain:

Aching Dull Ache Shooting Burning Sharp Throbbing Pins/Needles

Other: _____

Pain is: Getting better Getting worse Staying the same Can be pain free at times

Worse in the Early AM Afternoon Later PM Progresses as the day progresses

Do you have any of the following with your pain?

-Tingling/numbness in the Hands? Y N	Feet? Y N	-Pain radiating to the arm/forearm/hands? Yes No
-Weakness in the Hands? Y N	Feet? Y N	-Pain radiating to the thigh/buttocks/legs/feet Yes No
-Dragging of the foot while walking? Y N	Left Right	-Difficulty holding bladder or bowel movement Yes No

Which of the following affects your pain? Mark "B" for Better and "W" for worse

<input type="checkbox"/> Massage or rubbing	<input type="checkbox"/> Coughing	<input type="checkbox"/> Strong emotions	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Sudden movements	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Getting out of bed	<input type="checkbox"/> Running	<input type="checkbox"/> Coffee/Tea/Caffeine
<input type="checkbox"/> Noise	<input type="checkbox"/> Heat	<input type="checkbox"/> Sitting	<input type="checkbox"/> Bright light	<input type="checkbox"/> Eating
<input type="checkbox"/> Cold weather	<input type="checkbox"/> Lying down	<input type="checkbox"/> Walking	<input type="checkbox"/> Bending	<input type="checkbox"/> Sleep/Rest
<input type="checkbox"/> Vibration	<input type="checkbox"/> Ice	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Straining	<input type="checkbox"/> Distraction (i.e. TV, Reading)
<input type="checkbox"/> Wet climate	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Reaching	<input type="checkbox"/> Lifting	<input type="checkbox"/> Work/Hobbies

Other: _____

What assistive do you have to or need to use for walking or for support?

None Cane/walking stick Crutches Walker Brace Wheelchair Motorized scooter

Do you have stairs at home? Yes No How many in to the house: _____ In the house: _____

Do you have trouble navigating stairs? Yes No If yes, describe: _____

Have you fallen in the recent past? Yes No If yes, how many times. _____

SLEEP PATTERNS:

Do you have trouble falling asleep? Never 1-2 times/wk 3-5 times/wk 6-7 times/wk

How long does it take for you to fall asleep? _____

Do you wake up in the middle of the night because of pain? Never 1-2 times/wk 3-5 times/wk 6-7 times/wk

How long does it take for you to return to sleep? _____

Need for medication to sleep? Never 1-2 times/wk 3-5 times/wk 6-7 times/wk

What sleep medication do you take? (Include over-the-counter medications): _____

How many hours of sleep do you average per night? _____ Hours. Do you feel rested when you wake? Yes No

How many hours of sleep do you need to feel rested? _____ Do you take or need to take daytime naps? Yes No

Primary sleeping position: Back Left Side Right Side Stomach Number of pillows used: _____

Do you have any pets that sleep with you at night? Yes No _____

PAST MEDICAL HISTORY:**CURRENT OR PREVIOUS PHYSICAL THERAPY**

Are you currently receiving any other physical or speech therapy at this time? _____ Yes _____ No. If yes,

• Date of last physical therapy visits? _____ Number of visits this year: _____, Referred by: _____

Have you received any other physical or speech therapy in the past year for any reason? _____ Yes _____ No. If yes,

• Date of last physical therapy visit? _____ Number of visits: _____ Referred by: _____

PAST TREATMENT: Have you had any of the following treatments?

TREATMENT	When	Result	TREATMENT	When	Result
<input type="checkbox"/> Acupuncture			<input type="checkbox"/> Nerve Block		
<input type="checkbox"/> Biofeedback			<input type="checkbox"/> Epidural		
<input type="checkbox"/> Braces/Dentures			<input type="checkbox"/> Facet Injections		
<input type="checkbox"/> Exercise			<input type="checkbox"/> Radiofrequency		
<input type="checkbox"/> Herbal Remedies			<input type="checkbox"/> Psychotherapy		
<input type="checkbox"/> Hypnosis			<input type="checkbox"/> TENS Unit		
<input type="checkbox"/> Medications			<input type="checkbox"/> Traction		

Other: _____

Please list any prior injuries or surgeries (include joint replacements):**Please indicate any other medical conditions you currently have or have had in the past**

Cardiac Problems:	<input type="checkbox"/> Heart Disease <input type="checkbox"/> Heart Attack (date: _____) <input type="checkbox"/> High Blood Pressure		
Respiratory Problems:	<input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Emphysema <input type="checkbox"/> Other lung disease:		
Cancer: (Type and date)		Diabetes:	
Arthritis:	<input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid		
Neurological:	<input type="checkbox"/> Stroke (date:) <input type="checkbox"/> Balance/fainting spells <input type="checkbox"/> Seizures		

SOCIAL/OCCUPATIONAL HISTORY

Who are you currently living with (Check as many as apply):

- Live alone Spouse/partner Parents Roommate Children

Marital Status: Single Married Separate Divorced Widowed

Children living with you? Number _____ Ages: _____ Are you currently pregnant: Yes No

Please describe your home situation (who does most of the chores, stressful home life, satisfaction):

INFORMATION ABOUT YOUR HABITS:

In a typical week, how many days do you get exercise? _____ days/week

Current exercise routine: _____

Current activity level: Sedentary Low Medium Medium High High Competitive

Previous activity level: Sedentary Low Medium Medium High High Competitive

In a typical week, how many days do you drink alcohol? _____ days

In a typical day, how many drinks do you have? _____ (number of drinks)

(1 drink – 12 ounce can of beer, 4 ounces of wine, or 1 ounce shot of hard liquor)

Do you use tobacco? (Cigarettes, cigars, chewing tobacco, pipe, nicotine replacement) Yes No _____ packs/times/day

Consumption of caffeine: Caffeinated coffee, tea, sodas, energy drinks, chocolate: Quantity per week: _____

Do you get headaches after consuming caffeine? Yes No

Do you get headaches after a period of not having caffeine? Yes No If yes, how long do they last? _____

OCCUPATION: _____ Employer: _____

Length of time at this job? _____ Describe what you do? _____

How has this injury limited our ability to work/do your job? _____

Prior work history that may have affected your current pain: _____

What hobbies do you have? _____

How does your pain affect your ability to do your hobbies? _____

What are your goals/expectations for physical therapy for your: _____

PRIMARY Problem: _____

Secondary Problems: _____

