PHYSICAL THERAPY QUESTIONNAIRE

NAME: ____ DOB: ________________________

EMAIL ADDRESS: ______________________________________ PHONE #:_____________________

INSURANCE: ____ POLICY #:____________________

DOCTOR: ____ DIAGNOSIS: __________________

Do you have a follow-up appointment with your Doctor? ☐ Yes ☐ No Date: __________________

____

What is your main complaint? ____

____

What was the onset date of your CURRENT symptoms? (Please be specific):_________________________

Was it a sudden or gradual onset? ____

What treatments have you already tried? ____

____

Have you had Physical Therapy or Speech Therapy anywhere else? ___________________________

Have you had Wound Therapy anywhere else? ____

What tests have you had? (X-rays, CAT scan, MRI):_______________________________________

What medications are you taking? (List all):____

____

What is your pain level today (0=none & 10=worst)? ______/__10___ Pain location: ______________________

Lately, have you been getting better or worse?

____

What makes your pain better?

____

What makes your pain worse? ____

Describe 1 or 2 main activities you were able to do before the problem started that you are unable to do now:

____

What would you like to be able to do that you could do previously? ______________________

____

Any other significant medical problems we should know about?

____

____

DO YOU HAVE AN ALLERGY TO LATEX? ____________________________________

Any other comments:

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