Big Sky Physical Therapy

PATIENT QUESTIONNAIRE

To insure you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.

Name:____________________________

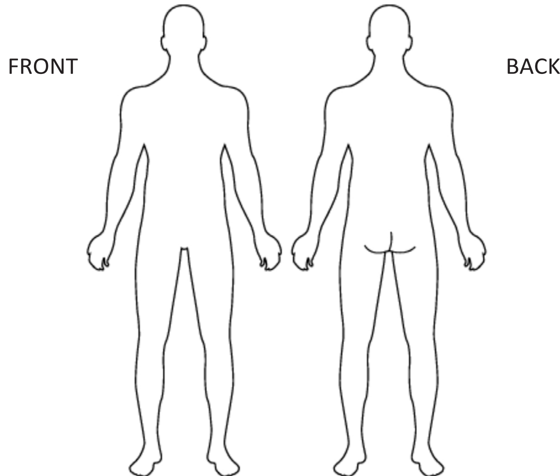
Date:________________**Age:**________

Weight:______________**Height:** ________

HISTORY OF PRESENT CONDITION

1. What are your symptoms?____________________

Localize areas of **pain** or **abnormal** sensation on the body chart below (Shade in where appropriate)



2. When did your symptoms begin?
(Please indicate a specific date if possible)____________

On a scale from 1-10 please indicate your level of pain?
(0 being "no pain" and 10 being "worst pain imaginable")______

3. Was the **onset** of this episode gradual or sudden? (check one)
- ☐ gradual ☐ sudden

4. Which of the following **best describes** how your injury occurred?
(if your condition is post-surgical please indicate as per original injury)
- ☐ lifting
- ☐ a MVA (car accident)
- ☐ a fall
- ☐ overuse (cumulative trauma)
- ☐ trauma
- ☐ degenerative process
- ☐ during recreation/sports
- ☐ running
- ☐ a blow to the face
- ☐ being hit by a ball
- ☐ a dental appointment
- ☐ throwing
- ☐ an incident at work
- ☐ unknown
- ☐ other____________

5. Since onset, are your symptoms getting: (check one)
- ☐ better ☐ worse ☐ not changing

6. Have you had similar symptoms in the past?
- ☐ Yes ☐ No

More than one episode?
- ☐ Yes ☐ No

7. Nature of pain/symptoms (check all that apply)
- ☐ sharp ☐ aching ☐ constant
- ☐ dull ☐ periodic ☐ other____________
- ☐ throbbing ☐ occasional ____________

8. As the day progresses, so your symptoms: (check one)
- ☐ increase ☐ decrease ☐ stay the same

9. Does the pain wake you at night? ☐ No ☐ Yes
if "*yes*", is it present
- ☐ while lying still
- ☐ only when changing positions
- ☐ both

10. Do you have pain/stiffness upon getting out of bed in the morning?
- ☐ Yes ☐ No

11. In what position do you sleep? (check all that apply)
- ☐ right side ☐ back ☐ other
- ☐ left side ☐ chair/recliner
- ☐ stomach ☐ back, sides, stomach

12. Since the onset of your current symptoms have you had:
- ☐ any difficulty with control of bowel or bladder function
- ☐ fever/chills
- ☐ any numbness in the genital or anal area
- ☐ numbness
- ☐ any dizziness or fainting attacks
- ☐ weakness
- ☐ unexplained weight change
- ☐ night pain/sweats
- ☐ malaise (vague feeling of bodily discomfort)
- ☐ problems with vision/hearing
- ☐ none of the above

13. What aggravates your symptoms? (check all that apply)
- ☐ sitting
- ☐ going to/rising from sitting
- ☐ household activities
- ☐ up/down stairs
- ☐ reaching overhead
- ☐ reaching in front of body
- ☐ reaching behind back
- ☐ reaching across body
- ☐ talking, chewing, yawning, all (circle one)
- ☐ recreation/sports including ____________ ____________
- ☐ repetitive activities
- ☐ lying down
- ☐ walking
- ☐ standing
- ☐ squatting
- ☐ sleeping
- ☐ coughing/sneezing
- ☐ taking a deep breath
- ☐ looking up overhead
- ☐ swallowing
- ☐ stress
- ☐ sustained bending
- ☐ other____________

14. What relieves your symptoms? (check all that apply)
- ☐ sitting
- ☐ heat
- ☐ cold
- ☐ stretching
- ☐ wearing a splint/orthosis
- ☐ rest
- ☐ standing
- ☐ walking
- ☐ exercise
- ☐ lying down
- ☐ massage
- ☐ medication
- ☐ nothing
- ☐ other________ ________

15. Have you had any previous treatment for this condition? (check all that apply)
- ☐ none
- ☐ medication (oral)
- ☐ joint manipulation
- ☐ exercise
- ☐ massage therapy
- ☐ traction
- ☐ bracing/taping
- ☐ injection into spine
- ☐ injection into skin/muscles
- ☐ physical therapy
- ☐ hypnosis
- ☐ biofeedback
- ☐ TENS unit
- ☐ acupuncture
- ☐ bed rest
- ☐ overnight hospitalization
- ☐ casting
- ☐ other____________

16. Have you had any of the following tests?

- ☐ none
- ☐ x-rays
- ☐ CT Scan
- ☐ MRI
- ☐ Arthrogram
- ☐ biofeedback
- ☐ Bone Scan
- ☐ Stress x-ray
- ☐ TENS unit
- ☐ Vestibular
- ☐ other______________ ______________

Test Results:____

MEDICATION

Please list any prescription medications you are currently taking *(pain pills, injections and/or skin patches, etc.)*:

____

____

Prescribing MD:__________________________Phone:__________

Are you currently taking any of the following over the counter medications?

- ☐ aspirin
- ☐ Tylenol
- ☐ corticosteroids
- ☐ antihistamines
- ☐ vitamins/mineral supplements
- ☐ Advil/Motrin/ibuprofen
- ☐ other__________________

PREVIOUS FUNCTIONAL LEVEL

☐ **Independent in all activities**
(work, community, home, recreation)

Self-care

- ☐ Independent in all self-care activities (bathing, toileting, dressing, etc.)
- ☐ Difficulty performing self-care activities
- ☐ Need assistance with self-care activities
- ☐ Difficulty performing household chores

Social

- ☐ Need assistance with activities in community outside of home

Hobbies:____

CURRENT FUNCTIONAL LEVEL

☐ **Independent in all activities**
(work, community, home, recreation)

Self-care

- ☐ Independent in all self-care activities (bathing, toileting, dressing, etc.)
- ☐ Difficulty performing self-care activities
- ☐ Need assistance with self-care activities
- ☐ Difficulty performing household chores

Social

- ☐ Need assistance with activities in community outside of home

Hobbies:____

WORK HISTORY

Occupation____

- ☐ employed full-time
- ☐ employed part-time
- ☐ self employed
- ☐ homemaker
- ☐ student
- ☐ retired
- ☐ unemployed
- ☐ other__________________

Physical activities at work (check all that apply)

- ☐ sitting
- ☐ standing
- ☐ phone use
- ☐ repetitive lifting
- ☐ heavy lifting
- ☐ computer use
- ☐ heavy equip. operation
- ☐ driving
- ☐ other__________________

Are you currently receiving or seeking disability for this condition?

☐ Yes ☐ No

If not performing your normal activities at work do you plan to RETURN to your previous activity level?

☐ Yes ☐ No

LIVING SITUATION

- ☐ live alone
- ☐ live with family members
- ☐ live with caregiver
- ☐ retirement complex
- ☐ home/apartment
- ☐ assisted living complex
- ☐ other__________________

Setting:

- ☐ stairs (railing)
- ☐ stairs (no railing)
- ☐ no stairs
- ☐ ramp
- ☐ uneven ground
- ☐ elevator
- ☐ other____

GENERAL HEALTH

How would you rate your average health?

☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor

Do you use exercise outside of normal daily activities?

☐ 5+ days/wk ☐ 3-4 days/wk ☐ 1-2 days/wk ☐ occasionally ☐ zero

Recreation activities consisting of:

- ☐ running
- ☐ biking
- ☐ swimming
- ☐ golfing
- ☐ tennis
- ☐ other__________________
- ☐ walking
- ☐ skiing

Do you drink caffeinated beverages?

☐ No ☐ Yes How many/much per day______________

Do you smoke?

☐ No ☐ Yes Packs of cigarettes per day______________

What is your stress level?

☐ Low ☐ Medium ☐ High

Are you seeing any health care providers other than the physical therapist for this current condition? (please list)

____

PAST MEDICAL HISTORY

Have you ever had/been diagnosed with any of the following condition? (check all that apply)

- ☐ Cancer (type)______________
- ☐ Depression
- ☐ Stroke
- ☐ Kidney problems
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Multiple sclerosis
- ☐ Arthritis
- ☐ Head injury
- ☐ Stomach problems
- ☐ Parkinson's disease
- ☐ Infectious disease (i.e. Hepatitis, Tuberculosis, etc.)
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Lung problems
- ☐ Blood disorders
- ☐ Epilepsy/seizures
- ☐ Allergies
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Broken bone
- ☐ Circulation/vascular problems
- ☐ other__________________

Please list any past surgeries related to you current problem:

SURGERY	DATE

FAMILY HISTORY

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for the following?

- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Stroke
- ☐ Cancer
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Psychological condition
- ☐ Other____