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

___Massage or rubbing	___Coughing	___Strong emotions	___Standing	__Alcohol
___Sudden movements	___Anxiety	___Getting out of bed	___Running	__Coffee/Tea/Caffeine
___Noise	___Heat	___Sitting	___Bright light	__Eating
___Cold weather	___Lying down	___Walking	___Bending	__Sleep/Rest
___Vibration	___Ice	___Physical Therapy	___Straining	__Distraction (i.e. TV, Reading)
___Wet climate	___Fatigue	___Reaching	___Lifting	__ 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
☐ Acupuncture			☐ Nerve Block		
☐ Biofeedback			☐ Epidural		
☐ Braces/Dentures			☐ Facet Injections		
☐ Exercise			☐ Radiofrequency		
☐ Herbal Remedies			☐ Psychotherapy		
☐ Hypnosis			☐ TENS Unit		
☐ Medications			☐ 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:	☐ Heart Disease ☐ Heart Attack (date: _____) ☐ High Blood Pressure		
Respiratory Problems:	☐ Asthma ☐ COPD ☐ Emphysema ☐ Other lung disease:		
Cancer: (Type and date)		Diabetes:	
Arthritis:	☐ Osteoarthritis ☐ Rheumatoid		
Neurological:	☐ Stroke (date:) ☐ Balance/fainting spells ☐ 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: