inTouch Physical Therapy

Physical Therapy Screening Questionnaire

To ensure a thorough evaluation, please provide this important information about your medical history.

Name _____ **DOB** _____ **Age** _____ **Height** _____ **Weight** _____

How would you **rate** your general health? (*circle one*) Poor / Fair / Good / Excellent

What brings you to PT today? (brief description of symptoms) _____

_____

Onset Date _____ **Sudden** / **Gradual** (*circle*) Are your symptoms: **New** / **Recurring** (*circle)*

Did this injury occur: at work / auto / other: _____

Have you had treatment/ diagnostic tests for this? Y N If yes, what? _____

What is your *GOAL* with Physical Therapy? _____

_____

List **THREE FUNCTIONAL ACTIVITIES** that you are currently having difficulty with due to current symptoms:

1. _____

_____

2. _____

_____

3. _____

_____

CIRCLE all of the following which apply to you:

Live alone / with family or caregiver

Live in home / apartment / retirement complex

Have stairs inside / into home

Cook and clean for self / others

Drive

Work / Retired

Occupation/ work activities: _____

_____

Current smoker

Have allergies (ie: latex)

please list: _____

HAVE YOU EVER BEEN DIAGNOSED WITH:

Diabetes	Y N	Date	_____
Stroke	Y N	Date	_____
Fibromyalgia	Y N	Date	_____
Osteoporosis/ osteopenia	Y N	Date	_____
Osteoarthritis	Y N	Date	_____
Scoliosis	Y N	Date	_____
Cancer	Y N		
Type	_____	Date	_____
Heart Problems	Y N		
Type	_____	Date	_____
Lung Problems	Y N		
Type	_____	Date	_____
Infectious Disease	Y N		
Type	_____	Date	_____

Other _____

Have you been or are you pregnant? Y N

Due date(s): _____

Have you fallen in the past year? Y N

How many times? _____ Were you injured? Y N

Where did fall(s) occur? _____

Do you exercise? Y N

If yes, how often? _____

What type of exercise? _____

_____

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List **ANY previous SURGERIES/ INJURIES/ MEDICAL CONDITIONS** (**even if not directly related**)

DATE SURGERIES/ INJURIES/ MEDICAL CONDITIONS REASON

_____

_____

_____

_____

_____

_____

_____

_____

Have you experienced any of the following in the **PAST 2 WEEKS?** (*please circle*)

Abdominal pain	Bowel/bladder changes
Chills	Dizziness
Fatigue	Fever
Headaches	Nausea/ Vomiting
Night sweats	Numbness/ Tingling
Sleep disturbance	Swelling
Unexplained weight loss/ gain	Weakness

What makes your **symptoms WORSE**? (*please circle*)

Bending	Coughing/Sneezing
Driving	Laying on side
Lifting	Lying down
Reaching	Repositioning in bed
Sitting	Sports
Stairs	Standing
Steps	Transitioning sit to stand
Walking	Working

Other _____

What makes your **symptoms BETTER**? (*please circle*)

Exercise	Heat
Ice	Medication
Position change	Resting
Sitting	Standing
Stretching	Walking

Other _____

Signature: _____

Date: _____

Do your symptoms WAKE you at night? Y N

If yes, do they wake you while:

Lying still? Y N

Changing positions? Y N

Other: _____

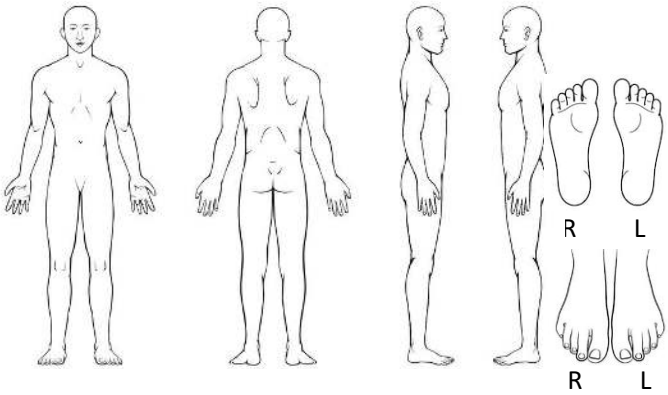
PAIN SCALE (0 = no pain, 10 = emergency room)

Current: ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

At **BEST**: ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

At **WORST**: ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

Please INDICATE on the diagrams your AREA(S) OF



NATURE OF SYMPTOMS (*please circle*)

Aching	Burning
Constant	Fluctuating intensity
Intermittent	Sharp
Shooting	Stabbing
Throbbing	Numbness
Other _____	Tingling

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