

STODDEN PHYSICAL THERAPY Patient Questionnaire

CONSENT: I understand that my diagnosis and treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered. _____

(Sign and Date)

Do you have any barriers to learning? Yes/No If "Yes", please list: _____

Past Surgical History: (list & date) _____

Current Medications: (dosage) _____

Gender: M / F Age: _____ Smoker: Y / N Pregnant: Y / N

Occupation: _____

Do you exercise at least 3 days per week? Y / N

Past Medical History: Please circle each condition that you have been told you have (or had):

Cancer	Diabetes	Kidney Disease	Liver Disease	Stroke
High Blood Pressure	Heart Disease	Angina/Chest Pain	Ulcers	Fibromyalgia
Osteoporosis	Osteoarthritis	Rheumatoid Arthritis	Sexually transmitted Disease	
Allergies/Asthma	Lung Disease	Have you had a recent illness: _____		
Do you take blood thinners? Y / N		Are you allergic to latex? Y / N		
Other: _____				

Currently, I am experiencing (circle all that apply):

Fever/chills/sweats	Unexplained weight loss/gain	Numbness/tingling	Change in appetite
Difficulty swallowing	Depression	Dizziness	Shortness of breath
Changes in bowel or bladder function		Nausea/Vomiting	Increases pain at night
Poor balance: Y / N			

Have you had 2 or more falls in the past 12 months or any fall with an injury? Y / N

How are you able to sleep at night? Fine Moderate Difficulty Only with medication

During the past month, have you often been bothered by feeling down, depressed or hopeless? Y / N

During the past month, have you often been bothered by little interest or please doing things? Y / N

What date (approximately) did your present pain start? _____

How (gradually, suddenly, injury)? _____

My symptoms are currently (circle one): Getting better / About the same / Getting worse

What treatment have you received for this problem so far? _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

Have you had an x-ray, MRI, or other imaging study for this problem? Y / N

Please circle the number which best represents the average level of pain you have experience over the past 48 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worse Pain Imaginable

What are your personal goals for Physical Therapy at this time? _____
