

**South Bay Sports Physical Therapy
PATIENT QUESTIONNAIRE/SUMMARY LIST**

To help us assess the cause of your problem, we ask you to complete this form before being seen by a Physical Therapist. Please answer as completely as possible.

First	Middle Initial	Last	Nickname
Name: _____			
Age: _____	Ht: _____	Wt: _____	
Have you lost or gained (unintentionally) 10 lbs. or more during the past 6 mths? YES NO		Is your doctor aware? YES NO	
Physician: _____		Phone: _____	Address: _____
Current Medical Conditions: _____			
Long Term Medications (prescriptions/over-the counter Meds/ herbal preparations) _____			
Allergies to Medications: _____			
Previous Operative/Invasive Procedures: _____			
Are You Pregnant? _____no _____yes _____ Not Applicable			
Do you have or have you had any of the following diseases or problems?			

Please circle

Congestive Heart Disease.....	YES	NO	Diabetes.....	YES	NO
High Blood Pressure.....	YES	NO	Thyroid Disease.....	YES	NO
Heart Birth Defect.....	YES	NO	Hepatitis or Liver Disease.....	YES	NO
Heart Attack.....	YES	NO	Stomach Ulcers.....	YES	NO
Angina Pectoris.....	YES	NO	Venereal Disease.....	YES	NO
Rheumatic Fever.....	YES	NO	Osteoporosis.....	YES	NO
Heart Murmur.....	YES	NO	AIDS/HIV Positive.....	YES	NO
Collagen or Vascular disease.....	YES	NO	Arthritis.....	YES	NO
Anemia.....	YES	NO	Hay Fever.....	YES	NO
Bleeding Problem.....	YES	NO	Respiratory Disease.....	YES	NO
Other Blood Disorder.....	YES	NO	Sinusitis.....	YES	NO
Stroke.....	YES	NO	Asthma.....	YES	NO
Convulsions or Seizures.....	YES	NO	Tuberculosis.....	YES	NO
Neurologic Disorder.....	YES	NO	Emphysema.....	YES	NO
Nervous or Psychiatric Condition.....	YES	NO	Bronchitis.....	YES	NO
Fainting Spells.....	YES	NO	Glaucoma.....	YES	NO
Kidney Disease.....	YES	NO	Cancer.....	YES	NO
Severe Headaches.....	YES	NO	Other		

Please specify any medical conditions you have that are not listed: _____

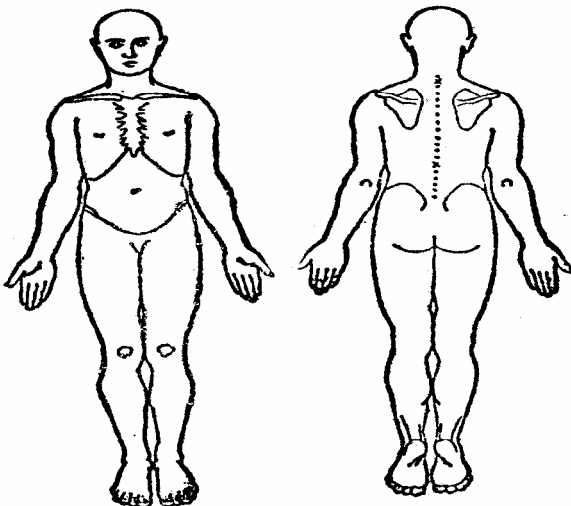
PERSONAL DATA RELATING TO THE PROBLEM FOR WHICH YOU HAVE BEEN REFERRED FOR PHYSICAL THERAPY

AREAS OF PAIN

PAIN INTENSITY

Where is the pain now (past 48 hours)? Please indicate painful areas by shading.

Please rate your pain level on a scale from 0 to 10



- | | |
|----|----------------|
| 10 | Maximal (8-10) |
| 9 | |
| 8 | |
| 7 | Moderate (4-7) |
| 6 | |
| 5 | |
| 4 | |
| 3 | Mild (1-3) |
| 2 | |
| 1 | |
| 0 | Nothing At All |

Pain Rating

Now: _____

Over Past 30 Days:

Best: _____

Worst: _____

Which of these words describe your pain? Please circle all that apply to you.

Sharp Numb Burning Throbbing Variable Worse in morning Worse at night
Dull Tingling Aching Pins & Needles Constant Worse in evening

How did your problem start: Please circle all that apply to you:

Work Injury Motor Vehicle Injury Sports Injury
Sudden Onset Gradual Onset

Other, please describe: _____

When did this problem start: _____

How did this problem start: _____

Has your pain changed since it's original occurrence? If so, How? _____

Are you currently working ? Yes _____ No _____ If no, are you not working as the result of this problem? Yes _____ No _____

Please give your occupation, and describe the physical demands of your job: _____

What are your usual (before injury) household/family activities? _____

What are your hobbies: _____

What changes in activity have been necessary because of pain? (Please be specific): _____

What activities increase your pain? _____

What do you do to decrease your pain? _____

What medical tests have you had pertaining to this problem? Where was it performed?

X-Rays YES NO _____

MRI YES NO _____

CT Scan YES NO _____

EMG YES NO _____

Have you had any other treatments for this problem? (ie. previous physical therapy, chiropractic, acupuncture, etc.): _____

What are your goals for Physical Therapy? _____

Date of your next Physician Appointment: _____

Signature: _____ Reviewed By: _____ Date: _____
Patient/Parent/Legal Guardian Physical/Occupational Therapist