Physical Therapy Pre-Exam Questionnaire

In order to evaluate your condition fully, please be as accurate as possible. Thank you.

Patient Name: _____ DOB: _____ Date: _____

1. What is your age? ..... _____

2. What is your gender? ..... Male / Female

3. What is your occupation? ..... _____

4. Are you working now? ..... Yes / No Part-Time / Full Time

5. Have you had physical therapy before? ..... Yes / No

6. Where is your pain/problem? ..... _____

7. What caused your pain/or problem? ..... _____

8. Approximately when did it start? ..... _____

9. Is it getting better, worse, or staying the same? ..... _____

10. Have you ever had this pain/problem before? ..... Yes / No

11. Is your pain constant (never goes away)? ..... Yes / No

12. Pain Scale. (0=NONE, 5=MODERATE, 10=EXTREME)

When your pain is at its worst: 0…..1…..2…..3…..4….5…..6…..7…..8…..9…..10

How it feels right now: 0…..1…..2…..3…..4….5…..6…..7…..8…..9…..10

When your pain is at its best: 0…..1…..2…..3…..4….5…..6…..7…..8…..9…..10

13. Are you taking any medication for this pain/problem? ..... Yes / No

-If yes, what and does it help? _____

14. Are any of your usual everyday activities affected?..... Yes / No

-If yes, describes how. _____

15. List all medical conditions you have (or were told you have)? _____

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