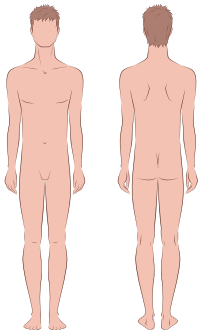
ORION PHYSICAL THERAPY

# Initial Questionnaire

| NAME | DATE | THERAPIST |
|---|---|---|
| | | |



**Date of injury/onset of symptoms:** _____

**What/where are your current symptoms?** *Mark and describe:* _____

_____

_____

**Which best describes how your injury/condition occurred:**

- o lifting
- o a fall
- o degenerative process
- o during recreation/sports
- o cumulative trauma/overuse
- o other: _____
- o car accident
- o trauma
- o running
- o unknown

**Where did your injury occur?**

- o at work
- o auto
- o other premises _____
- o at home
- o unsure

**Nature of symptoms:**

- o sharp
- o aching
- o numbness
- o other_____
- o dull
- o tingling
- o throbbing

**Frequency of symptoms:**

o constant o intermittent o occasional

Describe: _____

**State your pain level on a scale of 0 to 10:**

*(0 = no pain, 10 = hospitalized by pain)*

At rest ____ / 10 With activity _____ / 10

At worst _____ / 10

**Prior to this onset, have you experienced these symptoms in the past?**

o Yes o No Explain: _____

_____

**Have you had any operations on the body region associated with your present symptoms?**

o No o Yes Date _____

Type of surgery_____

**Does the pain wake you at night?**

o No o Yes _____ times per night

**Are your symptoms worse in the:**

o morning? o afternoon? o evening?

**Are your symptoms worse with:**

o sitting? o standing? o walking?

**What makes your symptoms worse?**

*Check all that apply.*

- o sitting
- o standing
- o walking
- o squatting
- o lying down
- o vacuuming
- o stress
- o swallowing
- o chewing
- o sleeping
- o making the bed
- o going to/from sitting
- o reaching out/overhead
- o reaching behind back
- o looking overhead
- o going up/down stairs
- o coughing/sneezing
- o taking a deep breath
- o doing dishes
- o sustained bending
- o up/down an incline
- o sports or recreational activities such as _____

_____

- o other: _____

_____

*Continued on back*

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**What relieves/lessens your symptoms?**

- o sitting
- o exercise
- o standing
- o heat
- o lying down
- o ice
- o changing positions
- o nothing
- o rest
- o stretching
- o alcohol
- o massage
- o other: _____

**What previous treatment have you had?**

- o none
- o traction
- o injections
- o bracing/taping
- o massage therapy
- o manipulation/adjustments by an osteopath or chiropractor
- o medication
- o physical therapy
- o TENS unit
- o exercise
- o other_____

**Have you had any of the following?**

o x-rays o MRI o CT Scan o other

Date _____

**Are you currently working?**

o yes o no Occupation _____

o part time o full time o restricted duty

**What positions are you in while working?**

o standing o sitting o walking o bending

o lifting: _____lbs frequency _____

**List any activities that you can't do now because of your injury/symptoms:** _____

_____

_____

**What goals would you like to achieve from therapy?** _____

_____

_____

**Have you had, or do you currently have any of the following medical conditions?**

- o cancer
- o pregnant *(currently)*
- o heart disease
- o joint disease/arthritis
- o pacemaker
- o recent surgery *(this year)*
- o high blood pressure
- o joint replacement
- o diabetes
- o history of seizures
- o breathing difficulties
- o osteoporosis
- o other: _____

_____

**Are you currently taking any prescription or over-the-counter medications?** *(Please list)* _____

_____

_____

_____

_____

_____

_____

THERAPIST SIGNATURE DATE