

# PHYSICAL THERAPY SOLUTIONS, LLC

## PATIENT QUESTIONNAIRE

1. What is your primary complaint? \_\_\_\_\_

2. When and how did your symptoms begin? \_\_\_\_\_

3. Have you had anything similar before? YES NO If yes, please state: \_\_\_\_\_

4. Were you free of symptoms before this onset? YES NO

5. Does your problem limit your ability to:

- a. sit                      b. stand                      c. walk                      d. sleep                      e. bend forward                      f. lift and carry
- h. climb stairs                      i. squat                      j. drive                      k. participate in your normal sport or recreational activities – please specify
- l. work                      m. other

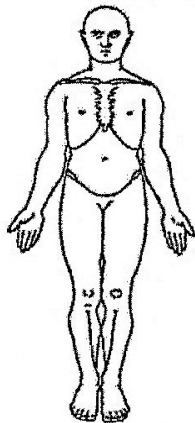
6. Mark on the diagram where you feel your symptoms:

**KEY**

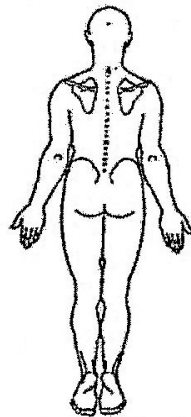
Pain: // // // // //

Numbness & Tingling: |·|·|·|

Other: →  
(write your symptoms)



Front



Back



Right side



Left side

7. What treatment have you had for this problem? \_\_\_\_\_  
Did it help? YES NO Are your symptoms \_\_\_\_\_ better \_\_\_\_\_ worse \_\_\_\_\_ same?

8. What makes your pain worse? \_\_\_\_\_

9. What eases your pain? \_\_\_\_\_

10. List your goals for therapy: \_\_\_\_\_

11. Surgeries? YES NO If yes, list \_\_\_\_\_

12. What medications are you currently taking? \_\_\_\_\_

13. Have you EVER been diagnosed as having any of the following:

- |   |                                 |
|---|---------------------------------|
| _____ Cancer                                | _____ Diabetes                  |
| _____ Heart problems                        | _____ Multiple sclerosis        |
| _____ High / low blood pressure             | _____ Rheumatoid arthritis      |
| _____ Circulation problems                  | _____ Other arthritic condition |
| _____ Bleeding disorder                     | _____ Depression                |
| _____ Asthma                                | _____ Hepatitis                 |
| _____ Emphysema / bronchitis                | _____ Tuberculosis              |
| _____ Chemical dependency (e.g. alcoholism) | _____ Stroke                    |
| _____ Thyroid problems                      | _____ Kidney disease            |
| _____ Anemia                                | _____ Epilepsy                  |
| _____ Other _____                           |                                 |

14. Have you recently noted:

- \_\_\_\_\_ Weight loss / gain
- \_\_\_\_\_ Nausea / vomiting
- \_\_\_\_\_ Dizziness / lightheadedness
- \_\_\_\_\_ Fatigue
- \_\_\_\_\_ Weakness
- \_\_\_\_\_ Fever / chills / sweats
- \_\_\_\_\_ Numbness or tingling
- \_\_\_\_\_ Other \_\_\_\_\_

Do you have any transplanted organs, metal implants or pacemaker? YES NO If yes, please specify: \_\_\_\_\_

**FOR WOMEN:** Are you currently pregnant or think you might be pregnant? YES NO