OLYMPIC PENINSULA PHYSICAL THERAPY

PATIENT INITIAL QUESTIONNAIRE

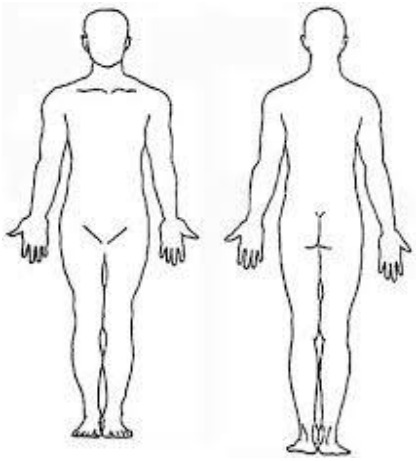
NAME: _____

DATE: _____

DATE OF BIRTH: _____

This form contains a series of questions designed to help your Physical Therapist evaluate your condition, track how you feel, and determine how well you are able to do your usual activities. This information will help your therapist and referring physician give you the best possible care. Please answer every question as accurately and completely as you can.

1. What are your symptoms/chief complaint? _____
   Indicate areas of pain or abnormal sensation on the body chart below
2. Which of the following best describes how your injury occurred? *(Check one)*
   □ Lifting □ Trauma □ Cumulative trauma/overuse
   □ MVA (car accident) □ Degenerative Process □ Other: _____
   □ Fall □ During recreation/sportsunknown
3. Where did your injury occur? □ At work □ Auto □ Personal home
   □ Other premise (please specify_____)
   □ N/A due to gradual onset
4. Date of injury/onset of symptoms: (mo/dy/yr) _____
   Please explain how the injury occurred:
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____



5. Nature of Symptoms *(Check all that apply)*
   □ Sharp □ Aching □ Tingling □ Dull □ Occasional
   □ Numbness □ Throbbing □ Constant □ Other:_____
6. Please indicate your pain level on a scale of 0 to 10 _____
   (0 = no pain, 1,2,3 = low pain, 4,5,6 = moderate pain, 7,8,9 = intense pain, 10 = emergency)
7. Have you had any falls in the past year? *(circle)* 0 1 2 3 4 >4
   Have you sustained any injury after the fall(s)? *(circle)* Yes No N/A
8. Have you ever had an operation on the body region associated with your current symptoms?
   □ No □Yes, Date: _____
9. Does the pain wake you at night? □ No □ Yes _____ □ Frequency? _____
   If "yes", is it present: □ While lying still? □ Only when changing positions? □ Both?
10. Are your symptoms worse in the: □ Morning □ Evening □ Neither
11. What aggravates your symptoms? *(check all that apply)*
    □ Sitting (how long) _____ □ Reaching overhead □ Coughing/sneezing
    □ Going to/from sitting □ Reaching out from body □ Taking a deep breath
    □ Standing (how long) _____ □ Reaching behind back □ Sleeping
    □ Kneeling/squatting _____ □ Reaching across body □ Looking up overhead
    □ Lying down _____ □ Sustained bending □ Swallowing
    □ Walking (how far/long) _____ □ Lifting _____ □ Stress
    □ Up/Downstairs_____ □ Getting dressed _____ □ Driving
    □ Household activities including _____
    □ Recreation/sports including _____
    □ Repetitive activities including: (gripping, typing, reaching, etc._____
    □ Other: _____

PLEASE COMPLETE OTHER SIDE

12. Please list any activities that you can't do now as a result of your current injury/symptoms:
_____

13. What relieves your symptoms? *(Check all that apply)*

□ Sitting	□ Exercise	□ Traction
□ Changing positions	□ Rest	□ Whirlpool
□ Standing	□ Cold	□ Medication
□ Lying	□ Heat	□ Alcohol
□ Walking	□ Massage	□ Nothing
□ Stretching	□ Splinting/brace wear	□ Other: _____

14. What previous treatment have you had related to your injury? *(Check all that apply)*

□ None	□ Bracing/Taping	□ TENS Unit
□ Medication (oral)	□ Traction	□ Massage Therapy
□ Injection into the spine	□ IME	□ Physical/Occupational Therapy

15. Have you had any of the following tests for current condition?
□ Arthrogram □ PCE □ CT Scan □ X-rays □ MRI □ Other _____
Results? _____

16. Do you exercise on a regular basis? □ No □ Yes
_____

17. Do you have access to exercise equipment/pool facilities? □ No □ Yes
_____

18. What goals would you like to achieve from therapy? _____
_____

19. What is your Height? _____ Weight? _____ BP: _____ HR: _____

20. Do you smoke? □ No □ Yes (how much?) _____

Please indicate if you have had or currently have the following medical conditions: □ UNREMARKABLE

□ Cancer	□ Heart disease	□ Pacemaker implant
□ High blood pressure	□ Diabetes	□ Changes in vision
□ Pregnant-currently	□ Bone/joint disorder/injury	□ Changes in hearing
□ History of seizures	□ Fractures	□ Bowel/bladder problems
□ Joint replacement	□ Breathing difficulties	□ Frequent headaches
□ HIV positive	□ Hepatitis C	□ Arthritis

□ Drug allergies _____

WORK HISTORY: Are you currently working?
□ No □ Yes, normal duty □ Yes, restricted duty □ Retired
Occupation (be specific):_____
Briefly describe your job duties: _____
_____

If you were injured on the job or work is affected by your current symptoms, please fill out questions 21 to 24.

21. Last day of full duty? _____ Is light duty available? □ No □ Yes

22. What positions are you in while working? (check all that apply) Indicate frequency:
S/Seldom, O/Occasional, F/Frequent
□ Sitting _____ □ Standing _____ □ Walking _____ □ Bending _____ □ Push/Pull _____
□ Kneeling/Squatting _____ □ Forward Reaching _____ □ Overhead Reaching _____
□ Repetitive grasp/pinch _____ □ Climbing (ladders/stairs, etc.) _____

23. Max weight carried (lbs):_____ Distance:_____
Max weight lifted from floor: _____ From knee to shoulder height: _____
Overhead: _____

24. Return to work goal: Job of Injury: □ No □ Yes □ Other _____

Therapist Signature:_____ Date:_____