# *Patient Questionnaire and History Survey*

Please fill this out to the best of your ability. Your therapist will review it with you Do not complete this form if you are in too much severe pain when writing sitting or standing at the counter.

NAME ____________________ DOB________ MALE ___ FEMALE ___

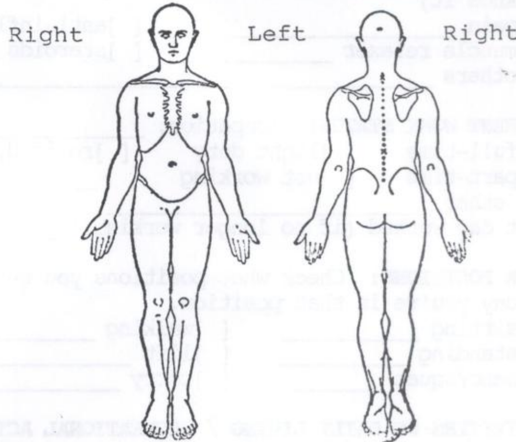
DATE __________ HEIGHT _____ WEIGHT _____ RIGHT HANDED ___ LEFT HANDED ___

DOCTOR ____________________ DIAGNOSIS ____________________

1. **DATE OF INJURY** (approximate): ______________

2. **ONSET:** Was onset of pain or other symptoms slow_____ or rapid_____?

3. **HOW INJURY OCCURRED:** describe (if you know) - (example: "I was lifting a 40 lb. box from the ground and rotated my trunk right and felt immediate pain in my low back and neck.")




4. **LOCATION:** On the body diagrams, draw where you have pain or other symptoms.

5. **PROGRESSION:** Check the box if you are:
   [ ]getting better [ ]staying the same [ ]getting worse

6. **IMPROVEMENT:** What percent are you already better in all of your painful areas?

7. **AGGRAVATING ACTIVITIES:** Check any activities that make your pain or symptoms worse. List how long you can do the activity before you have to stop due to too much pain.

[ ]standing _______
[ ]walking _______
[ ]lying flat on back _______
[ ]lying on stomach _______
[ ]sit to stand

[ ]sitting _______
[ ]bending _______
[ ]lying side w/knees bent _______
[ ]lift/carry
[ ]push/pull
[ ]overhead activities

[ ]cough/sneeze
[ ]sex
[ ]other ____________
____________
____________

**PLEASE CONTINUE ON OTHER SIDE**

OFFICE USE: Account # __________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(OVER PLEASE)

8. **EASING ACTIVITIES:** Check these if they decrease your pain or symptoms.
[ ]ice _______ [ ]rest _______ [ ]positions ___________________
[ ]heat _______ [ ]medication _______ [ ]other ___________________

9. **24-HOUR BEHAVIOR:**
a) number of times waking at night ____ reason ___________________________
b) are your symptoms better or worse in the following:
AM [ ]better DAY [ ]better PM [ ]better
[ ]worse [ ]worse [ ]worse
[ ]no change [ ]no change [ ]no change

10. **DIAGNOSTIC TESTS:** List dates and results
[ ]X-ray ____________________ [ ]Bone Scan ___________________________
[ ]MRI ______________________ [ ]C-T Scan ___________________________
[ ]Blood Study (ex: rheumatoid arthritis) ______________________________
[ ]other ___________________________________________________________

11. **MEDICATIONS:** Check the types of medication you are taking and list the name (if you know it)
[ ]pain ______________________ [ ]anti-inflammatory ___________________
[ ]muscle relaxer ____________ [ ]steroids ____________________________
[ ]others __________________________________________________________

12. **CURRENT WORK STATUS:** Occupation: _____________________________________
[ ]full-time [ ]light duty [ ]retired, previous occupation:
[ ]part-time [ ]not working ___________________________________
[ ] other ___________________________________________________________
last day worked (if no longer working): ___________________________

13. **WORK POSITIONS:** Check what positions you get into at work and what percentage of the day you're in that position.
[ ]sitting ___________ [ ]walking _________ [ ]push/pull ___________
[ ]standing __________ [ ]lift _____________ [ ]other _______________
[ ]bend/squat ________ [ ]carry ____________ _______________________

14. **ACTIVITIES OF DAILY LIVING / RECREATIONAL ACTIVITIES:**
a) Are there any activities which cause you increased symptoms at home? (example: vacuuming, sweeping, carrying groceries, dressing, driving, yard work, etc.)
_______________________________________________________________
b) Are there any recreational activities you are no longer able to participate in? (example: walking, sports, bicycling, etc.)
_______________________________________________________________

15. **PAST MEDICAL HISTORY:**
Have you had an injury to the same area you are being treated for now?
Yes ___ No ___ If so, when? ________________
How did injury happen? ______________________________________________

Have you ever been treated for this injury before? Yes___ No___ Did it help? ____
If so, when? ____________ What type of treatment? ______________
What percent was this area better prior to this current injury?

Problems:
[ ]heart [ ]lungs [ ]diabetes [ ]high blood pressure [ ]cancer
[ ]rheumatoid arthritis [ ]osteoarthritis [ ]pregnancy
[ ]other ___________________________________________

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