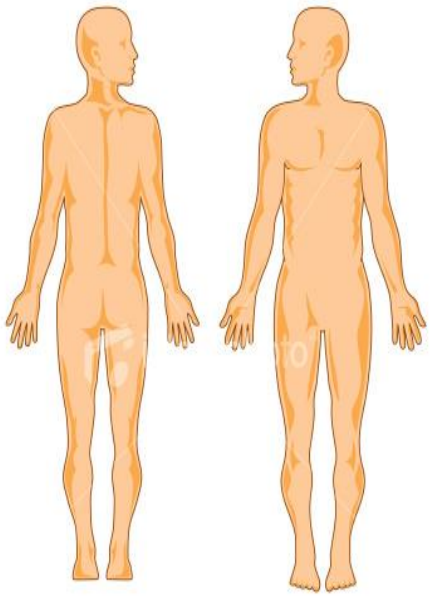
# Premier Physical Therapy Questionnaire

Name _____ Age_____ Date:_____

**Please answer the following questions as completely as you can. Please us back if you need more**

1. Briefly describe your problem: _____
_____
2. When did it start? _____ How did it happen?_____
_____
3. What was your pain like before your problem happened? _____
_____
4. What treatments have you had for this? _____
5. Have you had surgery for this condition? _____
6. Have you had x-rays, MRI's or other special tests? _____
If yes, which ones: _____
7. Circle the word(s) that best describe your pain: Sharp Dull Throbbing Numbness Shooting Burning Tingling
8. **Mark on the picture where the pain and symptoms are.**
9. Is your pain constant or intermittent (circle one)
10. Indicate your pain at best: No pain 1 2 3 4 5 6 7 8 9 10 Unbearable
11. Indicate your pain at worst: No pain 1 2 3 4 5 6 7 8 9 10 Unbearable
12. What makes your pain better? Standing Sitting Walking
    Other_____
13. What makes your pain worse? Standing Sitting Walking
    Other_____
14. Since your problem began, is it: Worse Better Same
15. Symptoms are worse: Morning Afternoon Night Or same all the time
16. Does your pain wake you up? _____ If yes, how many times? _____
    Describe:_____
17. What activities are required at work:
_____
18. Have you fallen in the past year? _____ If yes, how many times? _____
19. List all medications and dosages:
_____
_____



20. Have you had in the past or do you now have any of the following conditions: Y=Yes

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Allergies | **Y N** | Circulation Problems | **Y N** | Hepatitis | Y N | Osteoporosis | **Y N** |
| Anemia | **Y N** | Currently Pregnant | **Y N** | High Cholesterol | Y N | Parkinsons | **Y N** |
| Anxiety | **Y N** | Depression | **Y N** | High/Low Blood Pressure | Y N | Rhematoid Arthritis | **Y N** |
| Arthritis | **Y N** | Diabetes | **Y N** | HIV/AIDS | Y N | Seizures | **Y N** |
| Asthma | **Y N** | Dizzy Spells | **Y N** | Incontinence | Y N | Speech Problems | **Y N** |
| Autoimmune Disorder | **Y N** | Fibromyalgia | **Y N** | Kidney Problems | Y N | Strokes | **Y N** |
| Cancer | **Y N** | Fractures | **Y N** | Metal Implants | Y N | Thyroid Disease | **Y N** |
| Cardiac Conditions | **Y N** | Gallbladder Problems | **Y N** | MRSA | Y N | Tuberculosis | **Y N** |
| Cardiac Pacemaker | **Y N** | Headaches | **Y N** | Multiple Sclerosis | Y N | Vision Problems | **Y N** |
| Chemical Dependency | **Y N** | Hearing Impairment | **Y N** | Muscular Disease | Y N | | **Y N** |

21. Please list allergies:_____
22. Please list previous surgeries:_____
23. Are there any other conditions or things we should know:_____
_____

I certify the above information and medications are correct.

_____ _____

Patient's signature Reviewed by PT