Progressive Physical Therapy
New Patient Questionnaire

Name_____ Today's date_____

Diagnosis (if known)_____ Date of onset_____

Chief Complaint Today:_____

Recent Surgery? ___No___Yes *If YES, type_____Surgery Date_____

MEDICAL HISTORY (including surgeries, injuries, diseases)
I currently have or have had a HISTORY of: (check all that apply)

___High blood pressure
___Heart trouble/angina
___Pacemaker
___Diabetic
___Smoker/tobacco use
___Cancer/tumor
___Severe night pain
___Bowel/bladder problems
___Currently pregnant
___Seizures
___Osteoporosis
___Headaches
___Dizziness
___Asthma/shortness of breath
___Kidney problems
___Nervous disorder
___Allergies
___Metal implants
___Sensitive to heat/ice
___Vision problems
___Hearing problems
___Major injury to neck/back/ spine
___Blackouts/fainting
___Orthopedic injuries
___Surgeries
___Other condition

If you checked any of the above conditions, please take a moment to explain.

_____

_____

MEDICATIONS
Please list all medications you are currently taking.

_____

Rate your overall Health (please circle one): Excellent Good Fair Poor

Please rate your ability to function on a 0-100% scale, with 0% being unable to do anything and 100% being completely normal in all aspects of your life: _____%

Please rate your **pain** on a scale of 0-10, with 0 being ***no pain*** and 10 being the ***worst pain*** you can ever imagine.

Now: 0 1 2 3 4 5 6 7 8 9 10 **Best:** 0 1 2 3 4 5 6 7 8 9 10 **Worst:** 0 1 2 3 4 5 6 7 8 9 10

Location of your pain: _____

Please circle the best word(s) to **describe your pain:**
Sharp Dull Aching Burning Stabbing Shooting Other_____

What makes your pain better/worse?

_____

Previous physical therapy/occupational therapy care this year? ___Yes___ No *If YES, please explain.

_____

Lifestyle/Exercise Routine (please circle one):
Very Active/Athletic (5x/wk) Regular Exercise (1-3x/wk) Infrequent Exercise Sedentary

Goals for attending physical therapy:

_____