

Your Name: \_\_\_\_\_ MD: \_\_\_\_\_

Date: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

**Please answer the following Questions:**

- 1) What brings you to physical therapy: \_\_\_\_\_
- 2) Date of injury or surgery: \_\_\_\_\_
- 3) Have you had any diagnostic tests such as XRAY, MRI, CT Scan, EMG and where were they taken?  
\_\_\_\_\_

4) Nutritional: Nausea/vomiting/diarrhea > 3 days  Yes  No

5) Unintentional weight loss  Yes  No

6) Coughing or choking while eating  Yes  No

7) Please list any other medical conditions:

High blood pressure \_\_\_\_\_ Diabetes \_\_\_\_\_ Cancer \_\_\_\_\_

Heart Conditions \_\_\_\_\_ Pulmonary/Asthma \_\_\_\_\_ Surgeries List \_\_\_\_\_

Other joint problems \_\_\_\_\_ Other pertinent information \_\_\_\_\_

8) List current medications: \_\_\_\_\_

9) List allergies and adverse reactions: \_\_\_\_\_

10) Occupation \_\_\_\_\_ (circle one) working / off work / retired, since when \_\_\_\_\_

11) Leisure Activities or Sports: \_\_\_\_\_

12) List three activities that make your symptoms worse:

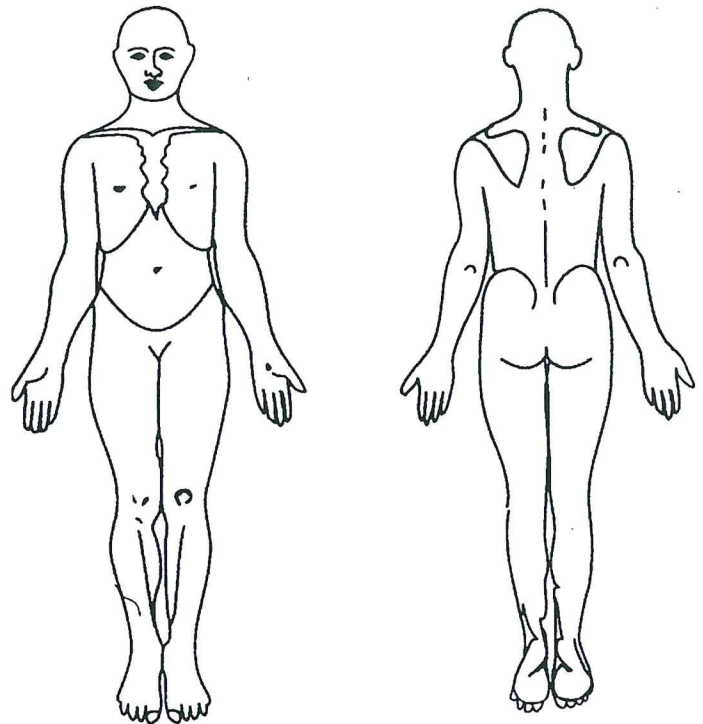
- 1.
- 2.
- 3.

13) List three activities that make your symptoms better:

- 1.
- 2.
- 3.

14) What are your goals for attending physical therapy?

15) Please draw on the body chart the affected area:



Pain Scale 1-10

Best \_\_\_\_\_

Worst \_\_\_\_\_

Present \_\_\_\_\_



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**PHYSICAL THERAPY QUESTIONNAIRE**



PTQUESTN

Patient Identification:

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_