Your Name: ______________________ MD: ______________________

Date: ______________________ Diagnosis: ______________________

Please answer the following Questions:

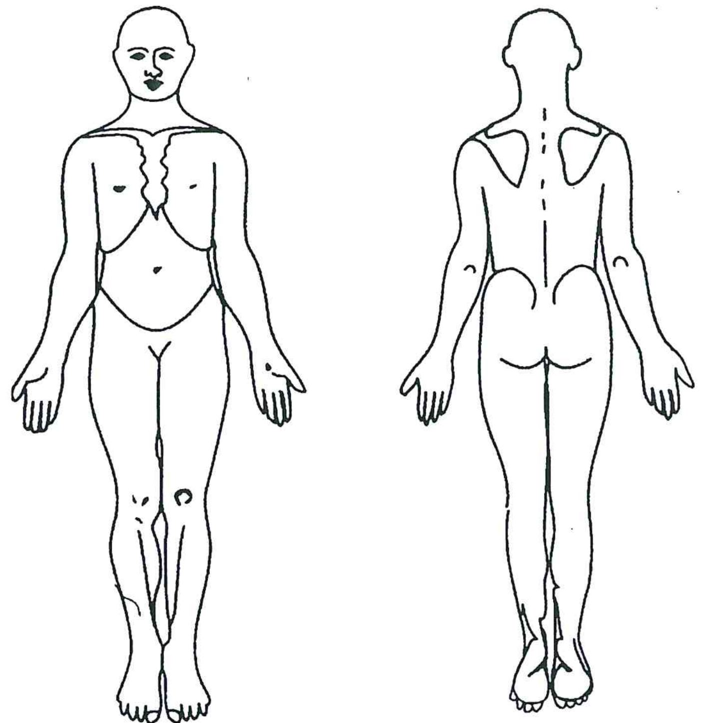
1) What brings you to physical therapy: ______________________
2) Date of injury or surgery: ______________________
3) Have you had any diagnostic tests such as XRAY, MRI, CT Scan, EMG and where were they taken?

   ____
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 ____________

Dignity Health. St. Mary's Medical Center

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PHYSICAL THERAPY QUESTIONNAIRE

PTQUESTN

Patient Identification:

NAME:

DOB: