



PATIENT QUESTIONNAIRE –EXTREMITY

Date: _____ Name: _____ Age: _____ Referring Dr. _____

Occupation _____ Is this work related? Yes/No

Are you presently working? Full time/ Part time With Restrictions? Yes/No

Have you experienced problems of this type before? (Explain) _____

Current symptoms begin? Date: _____ How did your symptoms arise? Auto Accident,

Falling, Bending, Lifting, No Apparent Reason, Other: (Describe): _____

Who have you consulted regarding this injury? Emergency room MD, Family Doctor, Specialist.
(Describe): _____

What treatment or testing have you received? X-ray, MRI, Cat Scan, Myelogram, Nerve-
Conduction Study, Physical Therapy, Chiropractic, Medication, Injection, Bracing, Orthotic,
Other? _____

If surgery date and type? _____

When do you return to see the doctor who referred you to therapy? Date and time: _____ Time: _____

Health Concerns? Heart, Hypertension, Stroke, Epilepsy, Cancer, Diabetic, Respiratory Disorder,

Pregnancy, Metal Implants, Pacemaker, Other: _____

Are you allergic to Latex, Lidocain, Cortisone, other: _____

List ALL current prescription and over the counter medications or ask front desk to make a copy of
your current medications: _____

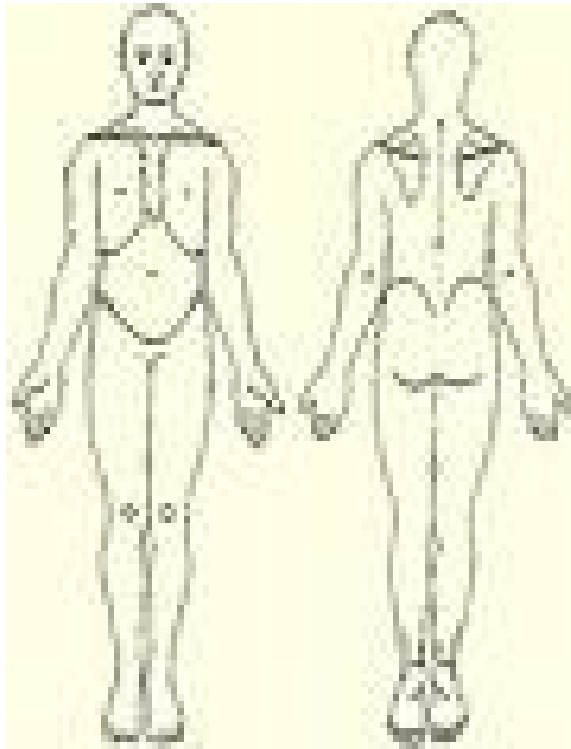
Do you participate in a regular exercise/sport program: Yes/No (Describe): _____

What are your goals for physical therapy? Decrease Pain, Improve Function, Return to Exercise, Other

On a pain scale from 0 to 10 please state your pain level: 0 being normal and 10 severe: _____

Please use the following words and indicate on the diagram where you feel the described symptom.

Aching: Numbness: Pins and Needles: Burning: Stabbing: Dull:



Attending Physical Therapist