

# peterson<sup>2</sup>

PHYSICAL THERAPY

## INITIAL PATIENT QUESTIONNAIRE FORM

IT IS IMPORTANT TO FILL THIS FORM OUT COMPLETELY

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_

1. Sex:  Male  Female  Right Handed  Left Handed Occupation: \_\_\_\_\_

2. Chief Complaint (where is your pain): \_\_\_\_\_

3. Onset Date (date of injury): \_\_\_\_\_

4. Type of injury/condition:  Gradual Onset  Work Comp.  Auto  Surgery  Sports  Other

5. Specifically describe your injury/condition: \_\_\_\_\_

6. Surgery Date: \_\_\_\_\_ Type of surgery: \_\_\_\_\_

7. Diagnostic testing related to this injury/condition:  X-Ray results: \_\_\_\_\_  MRI results: \_\_\_\_\_

8. Treatments related to your injury/condition: \_\_\_\_\_

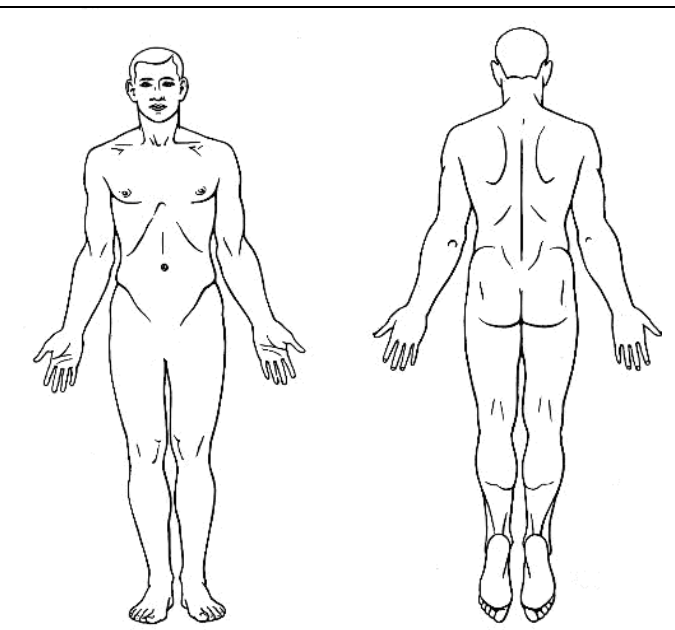
9. Circle the number that best represents your level of pain.

NO PAIN    0    1    2    3    4    5    6    7    8    9    10    WORST PAIN

10. What lessens your pain? \_\_\_\_\_

11. What activities are you having difficulty with as a result of your injury/condition?

1.) \_\_\_\_\_ 3.) \_\_\_\_\_  
2.) \_\_\_\_\_ 4.) \_\_\_\_\_

Where is the pain?											
Place symbols of your pain description on the body diagram on the left. This is to help us understand more about your symptoms. Please create your own symbols to describe your pain.											
	<table border="1"> <thead> <tr> <th>Pain Symbol</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td><b>X</b></td> <td>Sharp</td> </tr> <tr> <td><b>O</b></td> <td>Numbness</td> </tr> <tr> <td><b>A</b></td> <td>Achy</td> </tr> <tr> <td><b>S</b></td> <td>Stiffness</td> </tr> </tbody> </table>	Pain Symbol	Description	<b>X</b>	Sharp	<b>O</b>	Numbness	<b>A</b>	Achy	<b>S</b>	Stiffness
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12.(a) Have you had two or more falls in the past year?  Yes  No

(b) Have you had any falls with injury in the past year?  Yes  No

(c) Were any falls as a consequence of sudden onset of paralysis, epileptic seizure or overwhelming external force?  Yes  No