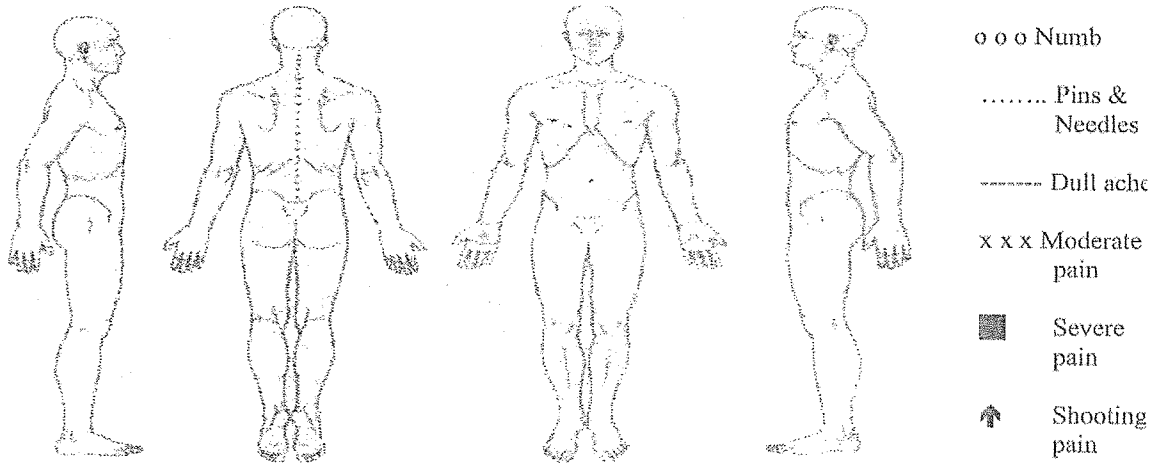
JACKSON COUNTY PHYSICAL THERAPY, LLP
PATIENT QUESTIONAIRE

Name: _____ Today's date_____
Date of Birth: _____ Age: _____ Date your problem began_____

PAIN LOCATION **Use key at right to fill in body → → → → →**



PAIN SEVERITY SCALE

0	1	2	3	4	5	6	7	8	9	10
None		Mild	Annoying Discomfort		Distressing Miserable		Agonizing Horrible		Excruciating Unbearable	

Choose the number of the word above that best describes the following:

____Your pain right now
____Your pain at its worst
____Your pain at its least

Frequency of Pain: Check one

_____Infrequent/Transient
_____Occasional
_____Constant/ Continuous

1. What is your present problem? _____
2. How did this problem start? _____
   _____
3. Please list anything you feel important or of interest to your current problem or pain:_____
   _____
   _____
4. Is your pain worse at any particular time of day? ___Yes. ___ No. If yes, when_____
5. What aggravates your pain? ___At rest ___Sitting ___Standing ___Awakens me
   ___Sneezing/Coughing ___Working ___Walking ___Sexual Intercourse
   ___All the time ___ Lifting ___Other (please specify)_____
6. What relieves your pain? ___Sitting ___Lying down ___Medications __Heat ___Ice
   ___traction ___massage ___walking ___Other (please specify)_____
7. Do you have difficulty sleeping? ___ Yes ___No Sleep position _____
8. At the present time are you getting: ___Better ___ Worse ____Stable
9. At the present time would you say your health is: __Excellent __Very good __ Fair __Poor
10. Do you have a Neurostimulator implant to control pain? ___Yes ___No

Please complete both sides
PATIENT QUESTIONAIRE

11. Do you (or have you recently) Suffered from any of the following?
___Numbness ___Malaise ___ Nausea/Vomiting ___ Dizziness
___Weakness ___Fatigue ___Fever/Chills/Sweats ___ Unexplained weight loss/gain

12. Are you or might be pregnant? ___Yes ___ No

13. Have you ever been diagnosed with or treated for any of the following conditions?

___Epilepsy/Seizures ___Liver disease ___Respiratory problems Type:_____
___Osteoporosis ___Diabetes ___Heart Problems Type: _____
___Arthritis ___Thyroid problems ___Cancer Type: _____
___High Blood Pressure ___Kidney problems ___Physical Disability
___Depression ___Neurological disorder (MS, stroke, Parkinson's) Other:_____
___Chemical Dependency (Alcoholism, Other) Other:_____

14. Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?
___Heart problems ___Diabetes ___Cancer ___ Headaches
___Stroke ___Mental illness ___Kidney Disease ___Liver Disease
___High Blood Pressure ___Osteoporosis ___Arthritis ___Physical Disability

15. Prior surgeries and approximate dates: _____
_____
_____

16. Have you seen any of the following medical personnel in the past 3 months?

a. Doctor or nurse practitioner: ___ Yes ___No Reason: _____
b. Osteopath: ___Yes ___No Reason: _____
c. Chiropractor ___Yes ___No Reason: _____
d. Psychiatrist/Psychologist ___Yes ___No Reason: _____
e. Other Reason: _____

17. Have you had physical therapy before? __Yes __No If Yes, was it for your current problem? __Yes __No

18. What treatment during physical therapy helped? (exercise, manipulation, traction, cold/hot packs, etc.)
_____

19. Recent Diagnostic Studies: __X-Rays __MRI __CT Scan __EMG __Ultrasound
Results: _____

20. Type of medical equipment used at home or in the community (walker, cane, oxygen, etc.)_____

21. Leisure activities, sports, hobbies, exercise:_____

22. Employment/Work (check all that apply): ___Full-time ___Part-time ___Light duty ___Unemployed
___Retired ___Student ___Homemaker ___Work with modification in job duty due to present problem
___Not working due to present problem

23. Occupation (title, type): _____

24. Where do you live (house, apartment, nursing home, etc.)? _____

25. With whom do you live (alone, spouse/significant other, child, etc.)?_____

26. Do you drink caffeinated beverages? ___Yes ___No How many drinks per day? _____

27. Any new life stresses? _____
_____

28. Medications: **Please complete additional document.**

Please complete both sides

Medication List
{please include prescriptions, over the counter, herbal supplements etc…}

Drug Name	Dose/ Frequency	Delivery Route (please check one)			
		Oral	Topical	Injection	Other (specify)
1-_____	_____				
2-_____	_____				
3-_____	_____				
4-_____	_____				
5-_____	_____				
6-_____	_____				
7-_____	_____				
8-_____	_____				
9-_____	_____				
10-_____	_____				
11-_____	_____				
12-_____	_____				
13-_____	_____				
14-_____	_____				
15-_____	_____				
		please use reverse for any additional medications			

Please initial appropriate box:

☐ **This <u>is</u> a complete list of my medications at this time. I will notify my therapist if there is a change to this list.**

☐ **This <u>is not</u> a complete list of my medications.**

Print Name:_____

Signature:_____ **Date:**_____