

PHYSICAL THERAPY INJURY QUESTIONNAIRE

Patient Name: _____ Date: _____

Shade in the area of your pain/injury

1. What was the date of your injury?

2. How did your injury occur?

3. Have you ever had this injury before?

Yes _____ No _____

4. Rate you pain on a scale of 1-10

(1= least pain, 5=moderate pain, 10=worst pain)

Sleeping _____

Running _____

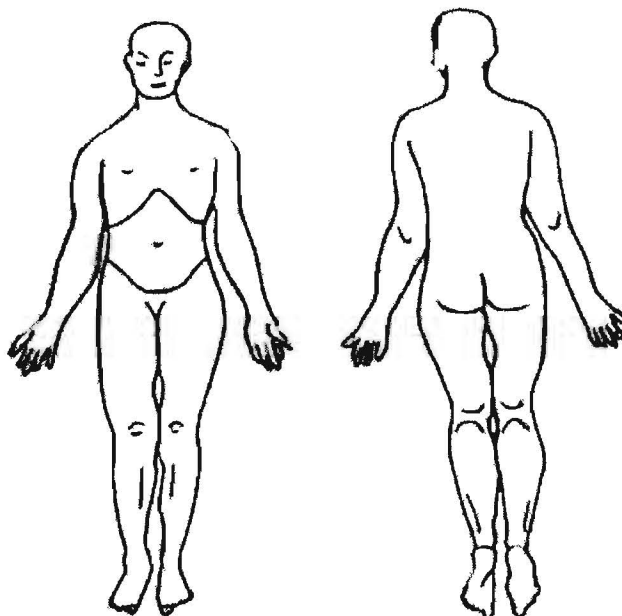
Other _____

Driving _____

Lifting _____

Standing _____

Walking _____



5. What makes your pain better? _____

6. What makes your pain worse? _____

7. What things can't you do now as a result of your injury? _____

8. Are you able to work because of this injury? Yes _____ No _____

9. Please list all medications that you are currently taking. _____

10. Check if you have had any of the following conditions:

_____ Asthma
_____ Hernia
_____ Arthritis

_____ Cancer
_____ Diabetes
_____ Epilepsy

_____ Heart Trouble
_____ Fainting Spells
_____ High Blood Pressure

_____ Shortness of Breath
_____ Allergy to Medicine
_____ Other