TRUE NORTH PELVIC PT PATIENT QUESTIONNARE

Name _____Pronouns_____DOB _____Date_____

Primary Care Provider _____Referring Provider _____

Occupation _____Activities_____

Concern for which you are coming to therapy _____

_____

How did it start?_____

Have you had this problem before? *Please circle* No Yes When did it start?_____

If you have pain, what increases your pain?

_____

If you have pain, what eases the pain?

_____

What medications are you taking?

_____

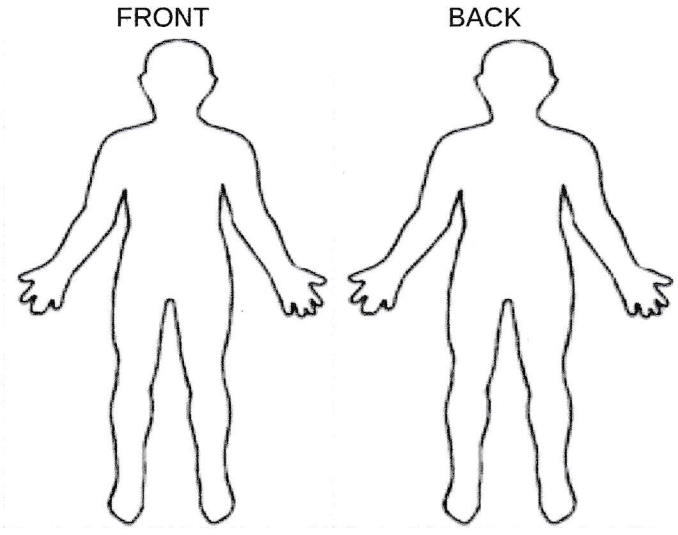
_____

Have you had special tests done related to this concern? *(Please circle)* No Yes

If you have pain, please describe your pain Aching ____ Burning ____ Throbbing ____ Sharp ____

Radiating ____ Tingling____Other_____ Is it Constant _____Intermittent _____

Please mark you area(s) of pain on the body diagram below and rate your pain on the scale beside it:



Please rate your current pain level:

At rest 0 1 2 3 4 5 6 7 8 9 10

With activity 0 1 2 3 4 5 6 7 8 9 10

0= None 5=Moderate 10=Extreme

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Your activities

To what extent are you able to carry out your everyday physical activities, such as walking, climbing stairs, carrying groceries, or moving a chair?

COMPLETELY MOSTLY MODERATELY A LITTLE NOT AT ALL

What tasks does your current concern cause difficulty with? *Check all that apply*

Work tasks _____ Self Care (dressing/bathing) _____ Household (cooking, cleaning etc) _____
Walking _____ Stairs _____ Sleep _____ Driving a car _____ Shopping _____ Sports _____

Caring for pet/animals ____Social participation _____Care giving for another person _____

Other_____

Your health

Please rate how well you are doing on a scale of 0 to 10 (0 represents "very well" and 10 represents "very poor" health). *Please circle below*

0 1 2 3 4 5 6 7 8 9 10

Prior medical history *check all that apply*

Heart problems _____ Lung problems _____ Joint problems _____ Skin problems _____

Dizziness _____ Balance problems _____ Neurologic conditions _____ Pain syndromes _____

Cancer _____ Incontinence issues ___ Any falls in the last year _____Visual problems _____

Hearing problems _____Other_____

Surgeries_____

What would you like to achieve through physical therapy, what are your goals for coming to therapy?

_____

_____