Patient Information Questionnaire

Name:_____ AGE: _____

EMAIL ADDRESS: _____

Injury Description

What is your main complaint and location of pain?_____

_____

When did the pain start? Date_____ or **When** was your surgery? Date_____

How did the injury occur? _____

Describe your level of function **before** injury: **Normal** **Restricted**, Please Specify: _____

What activities do you **currently** have difficulty with, due to your injury:_____

_____

Pain Rating

0 (no pain) **1** (some pain) **2** (mild pain) **3** (annoying pain) **4** (distracting pain) **5** (pain can't be ignored for long)

6 (pain can't be ignored at all) **7** (hard to think or sleep) **8** (pain stops activity) **9** (cry out in pain) **10** (can't talk)

Are your symptoms getting **worse – better - the same (circle one)** since your injury?

Please **circle** the tests you have had performed for your injury:

None *X Rays* *MRI* *CT Scan* *Bone Scan* *Other (Explain)*_____

Medical History

	Yes	No		Yes	No		Yes	No
Diabetes Type 1	____	____	Cancer	_____	____	Pacemaker	____	____
Diabetes Type 2	____	____	Aids/HIV	_____	____	Skin Allergies	____	____
Cardiovascular Disease	____	____	Pregnant	_____	____	Cold Allergies	____	____
Osteoarthritis	____	____	Osteoporosis	_____	____	Heat Allergies	____	____

List any medications & **dosages** you are taking: _____

When do you go back to your Doctor?_____

Are there any other complicating factors about your present health that we should know about? _____

_____

Are you currently, or have you in the last 3 months received any Home Health services (MD visits, nursing, wound care, physical therapy, etc.)? **Yes** or **No** If yes, when was their last visit? _____

Employment Information

Occupation:_____ Primary work duties:_____

Are you currently working? Y N If no, when did you last work?_____

If yes, are your work duties? Full Restricted

To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy services.

Patient Signature:_____ Date: _____