Andover
Physical Therapy

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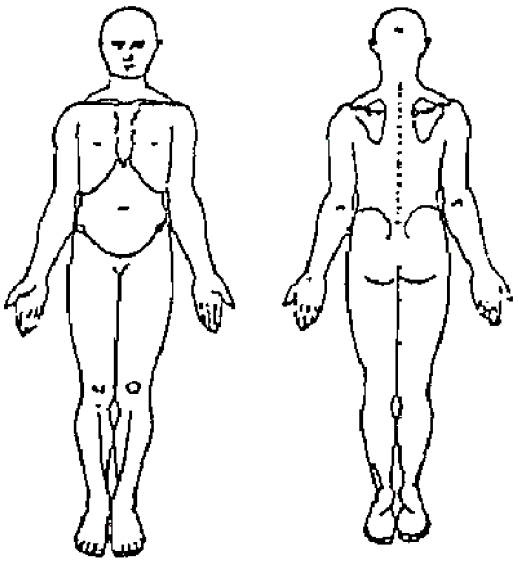
# Patient Questionnaire

Patient Name:_____ Date:_____

Please shade in the location of your pain and describe your pain.



_____

_____

_____

_____

_____

_____

_____

_____

What prior treatment have you received? (i.e. surgery, chiropractic, physical therapy, etc.)_____

_____

_____

Are you presently pregnant? YES NO

What medications are you currently taking?_____

_____

Please describe when and how you were injured? Date:_____ How:_____

_____

_____

Rate your activity level at this time. (circle one) 0 1 2 3 4 5 6 7 8 9 10
inactive very active

What activities have you had to limit because of pain?_____

_____

What makes pain worse?_____

What eases pain?_____

Rate the intensity of your pain now. (circle one) 0 1 2 3 4 5 6 7 8 9 10
no pain intense pain

What do you expect to gain from physical therapy?_____

_____