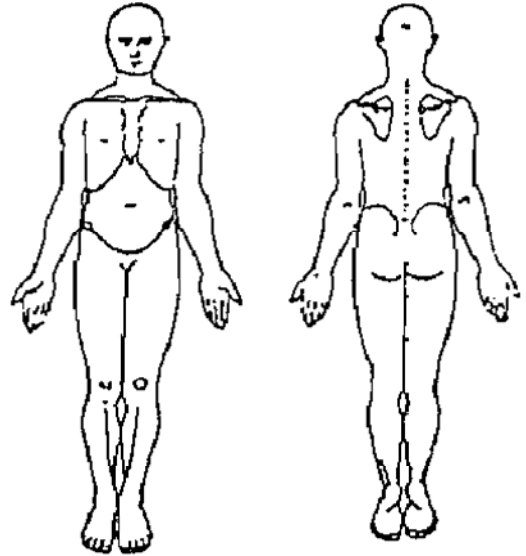


Patient Questionnaire

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? _____
