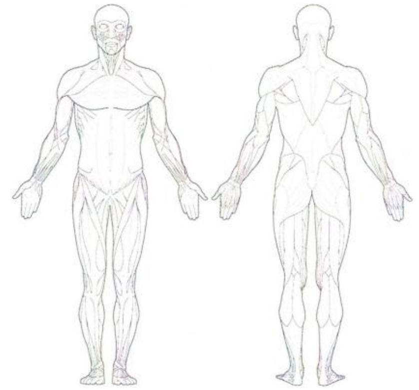
Physical Therapy Pre-Exam Questionnaire

In order for us to evaluate your condition fully, please be as accurate as possible. Thank you!

Name: ____________________________ DOB: _____/____/_______ SSN: ______-______-________

Indicate areas of pain below



1. Have you had physical therapy before? ☐ Yes ☐ No
2. What is your occupation? ________________________
   - Are you working now? ☐ Yes ☐ No
3. Where is your pain/problem? ________________________
4. What caused your pain/or problem? ________________________
   ____
5. Approximately when did it start? _____/_____/________
6. Is it getting worse, better, or staying the same? ________________________
7. Have you ever had this pain/problem before? ☐ Yes ☐ No
8. Is your pain constant (never goes away)? ☐ Yes ☐ No
9. On the scale below circle your worst pain level in the past couple of days:

   Mild *Moderate* *Severe*

   0 . . . . 1 . . . . 2 . . . . 3 . . . . 4 . . . . 5 . . . . 6 . . . . 7 . . . . 8 . . . . 9 10

10. Are any of your usual everyday activities affected? ☐ Yes ☐ No
    - If yes, describe how.____
    ____
11. Are you taking any medication? ☐ Yes ☐ No
    - If yes, what and dosages?____
    ____
12. List all past surgeries with dates:____
    ____
13. Please check all applicable conditions (past or present):

☐ Cancer	☐ Diabetes	☐ Stroke
☐ Heart Problems	☐ Asthma	☐ Rheumatoid Arthritis
☐ Pacemaker	☐ Anemia	☐ Osteoporosis
☐ High Blood Pressure	☐ Epilepsy	☐ Depression
☐ Emphysema	☐ Allergies (including latex)	
☐ Multiple Sclerosis	Please List Others ________________________	

14. Are you currently pregnant? ☐ Yes ☐ No Due Date if Yes ______/_____/________

I verify that the above information is truthful and accurate and I consent to evaluation and treatment by Full Motion Physical Therapy.

Signature:____ Date:______/_____/_______

FULL MOTION PHYSICAL THERAPY, LLC

Intake Questionnaire **Physical Therapist Initials__________**