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**Physical Therapy Questionnaire**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ SSN#: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Present Chief Complaints**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Symptoms Presentation ( Circle or fill in blanks for all that apply )**

Onset of symptoms:      Gradually                      Immediately

The pain is:                      Constant                      Comes & Goes                      At rest

According to a pain scale of 0-10 (0=no pain), the pain is currently a: \_\_\_\_\_, at its best a: \_\_\_\_\_, at its worst: \_\_\_\_\_

Any unusual sensations?                      Pins & Needles                      Tingling                      Numbness

Since onset pain is:                      Worse                      Same                      Improving

What activities increase your pain? \_\_\_\_\_

What activities decrease your pain? \_\_\_\_\_

The symptoms are better:                      AM                      PM                      As the day progresses

The symptoms are worse:                      AM                      PM                      As the day progresses

Disturbed Sleep?                      Yes                      No                      Difficult positions: \_\_\_\_\_

**Previous/Current Treatment**

Physician                      Physical Therapy                      Chiropractic                      Injections                      Rest                      Massage

Hot & Cold                      Exercise                      Traction                      Aquatherapy                      Self- Treatment

Other: \_\_\_\_\_

**Diagnostic Testing:**      X-ray                      EMG                      MRI                      CT scan                      Bone Scan

**Lifestyle**

Recreational activities prior to onset: \_\_\_\_\_

\_\_\_\_\_

Current activities able to participate in: \_\_\_\_\_

\_\_\_\_\_

**Functional Limitations:**

What activities are you unable to perform currently? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Past Medical History:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patient Goals for Physical Therapy:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have or have you recently had any of the following complaints?

- |                                                                        |                                                                                                  |
|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Shortness of breath                           | <input type="checkbox"/> Change or problems with bladder function (i.e. Urinary tract infection) |
| <input type="checkbox"/> Pain or a feeling of heaviness in your chest  | <input type="checkbox"/> Change or problems with bowel function                                  |
| <input type="checkbox"/> Pulsating pain anywhere in your body          | <input type="checkbox"/> Unusual menstrual irregularities                                        |
| <input type="checkbox"/> Constant and severe pain in lower leg (calf)  |                                                                                                  |
| <input type="checkbox"/> Discolored or painful feet                    | <input type="checkbox"/> Changes in hearing                                                      |
| <input type="checkbox"/> Dizziness or lightheadedness                  | <input type="checkbox"/> Frequent or severe headaches                                            |
| <input type="checkbox"/> Swelling                                      | <input type="checkbox"/> Problems with swallowing or changes in speech                           |
| <input type="checkbox"/> High Blood Pressure                           | <input type="checkbox"/> Changes in vision (ie: blurred vision or loss of sight)                 |
| <input type="checkbox"/> Heart Trouble                                 | <input type="checkbox"/> Problems with balance or falling                                        |
| <input type="checkbox"/> Stroke                                        | <input type="checkbox"/> Fainting spells                                                         |
|                                                                        | <input type="checkbox"/> Problems with coordination                                              |
| <input type="checkbox"/> Persistent pain at night                      | <input type="checkbox"/> Sudden weakness                                                         |
| <input type="checkbox"/> Constant pain anywhere in your body           | <input type="checkbox"/> Numbness or tingling (areas of decreased sensation)                     |
| <input type="checkbox"/> Unexplained weight loss (10-15lbs in 2 weeks) |                                                                                                  |
| <input type="checkbox"/> Loss of appetite                              | <input type="checkbox"/> Fever or night sweats                                                   |
| <input type="checkbox"/> Unusual lumps or growths                      | <input type="checkbox"/> Recent severe emotional disturbances                                    |
| <input type="checkbox"/> Fatigue                                       | <input type="checkbox"/> Swelling or redness in any joints                                       |
|                                                                        | <input type="checkbox"/> Pregnant                                                                |
| <input type="checkbox"/> Frequent or severe abdominal pain             | <input type="checkbox"/> Excessive bleeding from a cut, surgery                                  |
| <input type="checkbox"/> Frequent heartburn or indigestion             | <input type="checkbox"/> Diabetes                                                                |
| <input type="checkbox"/> Frequent nausea or vomiting                   | <input type="checkbox"/> Asthma                                                                  |
|                                                                        | <input type="checkbox"/> Paralysis                                                               |
| <input type="checkbox"/> Any blood transfusions                        | <input type="checkbox"/> Epilepsy or seizures                                                    |
| <input type="checkbox"/> Tuberculosis                                  |                                                                                                  |
| <input type="checkbox"/> Hepatitis B/C (circle)                        |                                                                                                  |
| <input type="checkbox"/> HIV Positive                                  |                                                                                                  |
| <input type="checkbox"/> Venereal Disease                              |                                                                                                  |
| <input type="checkbox"/> Any reaction to serum or medicine:            |                                                                                                  |
| _____                                                                  |                                                                                                  |
| <input type="checkbox"/> Allergies: what type: _____                   |                                                                                                  |
| _____                                                                  |                                                                                                  |