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Physical Therapy Initial Evaluation

Pre-Exam Questionnaire

Name of Patient: _____ Date _____

1. What is your age? _____ Height: _____

2. What is your gender? _____ Weight: _____

3. What is your occupation? _____ Blood Pressure: _____

4. Are you working now? _____

5. What is your pain or problem? _____

6. What caused it and when did it start? _____

7. Is it getting worse, better, or staying the same? _____

8. Have you ever had this pain/problem before? _____

9. Is your pain constant (never goes away)? _____

10. Have you had Physical Therapy Before, if yes where & when? _____

11. 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

12. Do you have a history of falls? _____

13. Are you taking any medication/ Supplements? If yes, **ALL MEDICATION MUST** list names and dosage you are taking?

14. Are any of your usual everyday activities affected? If yes, describe how? _____

15. List all past surgeries with dates: _____

16. List all medical history: _____
