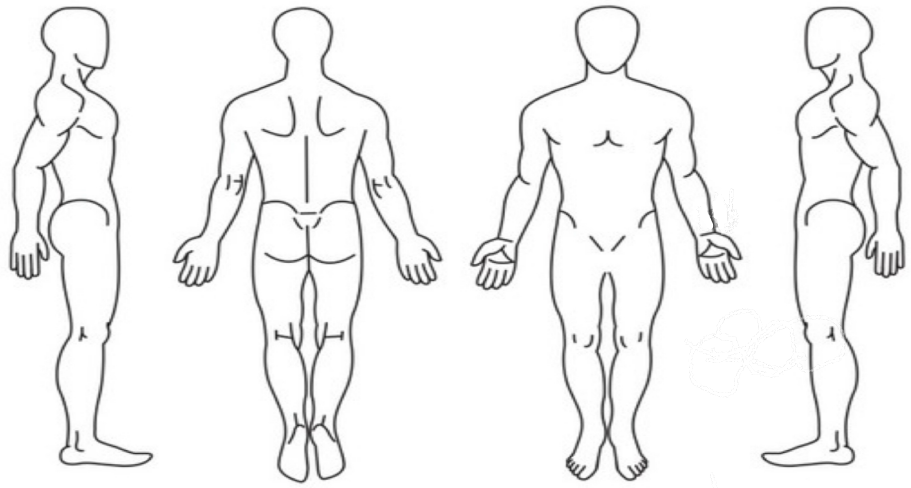
Amber Cross Physical Therapy
Patient Questionnaire

Name:_____Legal Sex_____ Pronouns:_____ Date:_____

Age:_____ Height/Weight:_____ Date your problem began:_____

Pain location – Use key to the right to fill in body chart



000 Numb
..... Pins + Needles
_ _ _ Dull Ache
xxxx Moderate Pain
■ Severe Pain
⬆ Shooting Paine

Pain severity Scale

0	1	2	3	4	5	6	7	8	9	10
None	Mild	Annoying discomfort		Distressing miserable			Agonizing Horrible		Excruciating Unbearable	

Choose a number from above
That best describes the following:
____Your pain right now
____Your pain at its worst
____Your pain at its least

Frequency of pain: Check one
_____Infrequent / transient
_____Occasional
_____Constant / Continuous

1. Describe your present problem: _____

_____

_____

_____

_____

2. Is your pain worse at any particular time of day? ___Yes ___No When? _____

3. What makes your pain worse? _____ Sitting ____ Standing ____ Walking ____ Working ____ Lifting ____ Lying down/sleeping

___Sexual intercourse ___Sneezing/Coughing Other (specify)_____

4. What makes your pain better? ____ Sitting ____ Standing ____Walking ____ Lying down ____ Medications ____ Heat ____ Ice

____ Traction ____ Massage Other (specify)_____

5. Do you have difficulty sleeping? ____ Yes ____ No Sleeping position_____

6. At the present time are you getting: ___Better ___Worse ___Stable

7. At the present time, would you say your health is: ____ Excellent ____ Very good ____ Fair ____ Poor

8. Do you have any electronic implants? ___ Yes ____ No If yes, what_____

9. Are you experiencing any of the following? ____ Numbness ____ Vision Changes ____ Nausea/Vomiting/Fever/Chills/Sweats

___Dizziness ___Headaches ___Severe night pain ___ Weakness ___ Fatigue ___Unexplained weight loss/gain

___Bowel or bladder changes ___Suicidal Ideation ___Abuse

10. Are you, or might be, pregnant? ___Yes ___No

11. Have you ever been diagnosed with, or treated for, any of the following conditions?

___Epilepsy/Seizures	___Liver disease	___Respiratory issues: type_____
___Osteoporosis/penia	___Addictions	___Heart issues: type_____
___Rheumatoid Arthritis	___Autoimmune	___Cancer: type/when_____
___High Blood Pressure	___Kidney issues	___Physical disability: type_____
___Depression/Anxiety	___Diabetes: type___	___Thyroid issues: type_____

___Neurological disorders (MS, stroke, Parkinson's) Other:_____

___Other:_____

12. Has anyone in your immediate family (parents, siblings) ever been treated for the following:

___Heart problems	___Diabetes	___Cancer	___Stroke
___Mental Illness	___Kidney Disease	___Liver Disease	___Physical Disability

13. Prior surgeries and approximate dates:_____

_____

_____

14. Recent diagnostic studies: ___X-rays ___MRI ___CT scan ___EMG ___Ultrasound

Results: _____

_____

16. Have you had physical therapy before? ___ Yes ___ No

17. Are you currently in Physical Therapy for this or any other problem? ____Yes ____No

17. What are your goals for Physical Therapy?_____

_____

18. Typical exercise and how often? _____

19. Type of medical equipment used: (walker, cane, oxygen, etc.)_____

20. Leisure activities, sports, hobbies: _____

21. Employment/Work:_____

22. Do you live alone? ___Y ___N and do you require help caring for yourself or your home?_____

23. Have you had any falls recently? _____

23. Do you drink caffeine/energy/alcoholic beverages ___No ___Yes: type and amount _____

24. Do you smoke/vape? ___No ___Yes: type and amount_____

List any allergies:_____

Medications: Please list below:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____