

Physical/Occupational Therapy Pre-Exam Questionnaire

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

1. What is your age? _____
2. What is your gender? Male Female
3. What is your occupation? _____
- Are you working now? Yes No
4. Have you had physical/occupational therapy before? Yes No
5. Where is your pain/problem? _____
6. What caused your pain/or problem? _____
7. Approximately when did it start? ____/____/20____
8. Is it getting worse, better, or staying the same? _____
9. Have you ever had this pain/problem before? Yes No
10. Is your pain constant (never goes away)? Yes No
11. On the scale below circle your worst pain level in the past couple of days:

<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>
0 ... 1 ... 2 ... 3 ... 4 ... 5 ... 6 ... 7 ... 8 ... 9 ... 10		
12. Are you taking any medication for this pain/problem?
- If yes, what and does it help? Yes No
13. Are any of your usual everyday activities affected?
- If yes, describe how. Yes No
14. List all past surgeries with dates:
15. List all medical conditions you have (or were told you have)?

Patient Name: _____

Signature: _____

Date: _____