in Touch
Physical Therapy

Physical Therapy Screening Questionnaire

To ensure that you receive a thorough evaluation, please provide us with this important background information about your medical history.

Name ______________________________ **Date of Birth** __________ **Age** _____
Date of onset or injury____________ **How this injury occurred** ______________________________
Please describe your current complaint ____

What makes your symptoms BETTER? *Please circle*
Heat Standing Resting Medication
Ice Sitting Walking Position change
Other ______________________________

What makes your symptoms WORSE? *Please circle*
Bending Driving Lifting Walking Sitting Sports
Standing Steps Stairs Working Overhead reaching
Other______________________________

Have you sought previous treatment *for this injury*?
____

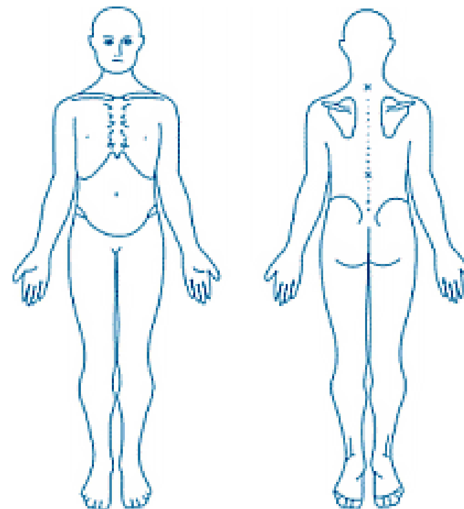
Please list any Tests / Findings
X-Ray / MRI / CT Scan____________________

Are you currently working? Y N **With restriction?** Y N
If no, when was the last day of work? ______________
Occupation:______________________________

Have you had any of the following in the past *2 weeks*?
Sleep disturbance Night sweats Night pain
Weakness Numbness Dizziness
Tingling Fatigue Headaches
Swelling Vomiting Abdominal pain
Nausea Fever Chills
Changes in bowel or bladder habits
Unexplained weight loss / gain

Please indicate your pain on a scale of 0-10, with 0 being no pain, and 10 being the worst pain imaginable (*please circle*)
0 1 2 3 4 5 6 7 8 9 10

Which of the following symptoms are you experiencing?
Please circle and label on the diagram:
Dull Shooting Sharp Constant
Ache Tingling Burning Numb
Other____________________



Have you ever been *diagnosed* as having any of the following conditions?
Y N Pregnancy?: Due date______________
Y N Diabetes
Y N Heart Problems
Y N Cancer: Type___________ Date_______
Y N Osteoporosis
Y N Stroke
Y N Smoking Habit
Y N Fibromyalgia

List **ANY SURGERIES/INJURIES/MEDICAL CONDITIONS** that would be important or helpful for us to know
Date: **Injury/Surgery/Medical Conditions:** **Reason**:
____
____
____

Which of the following **Over-the-Counter** and **Prescription** medications have you taken in the past **2 weeks**?
Please list how many.
____ **Prescription Medications** ______________________________
____ **Over-The-Counter Medications**______________________________

Do you have any product allergies? ie. Latex etc. *please list* ______________________
How would you rate your general health? Poor / Fair / Good / Excellent
Patient Signature ______________________ Date__________

7421 SW Bridgeport Road, Suite 215 Tigard, Oregon 97224
Tel. 503.620.2400 Fax 503.620.2410