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

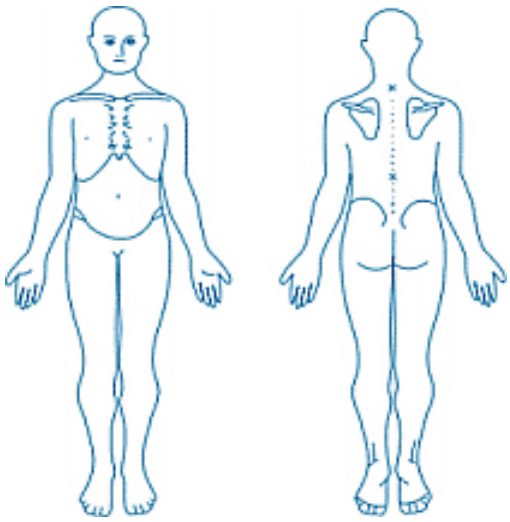
Changes in bowel or bladder habits
Unexplained weight loss / gain

Have you ever been *diagnosed* as having any of the following conditions?

Y	N	Currently Pregnant? Duedate:_____	Y	N	Osteoporosis
Y	N	Diabetes	Y	N	Stroke
Y	N	Heart Problems	Y	N	Smoking Habit
Y	N	Cancer: Type_____ Date_____	Y	N	Fibromyalgia

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_____



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_____

8100 SW Nyberg Street, Suite 130 Tualatin, Oregon 97062
Tel. 503.885.8677 Fax 503.885.0676

in Touch

Physical Therapy

Patient_____ Intake reviewed with patient: Y N

Subjective:_____

_____

_____

_____

Physical Therapy Evaluation: Objective

	AROM R	AROM L	PROM R	PROM L

Reflexes

Biceps (C5) L R	Patellar Tendon (L3-4) L R
Brachioradialis (C6) L R	Hamstrings (L5) L R
Triceps (C7) L R	Achilles (S1) L R

	R	L		R	L
Neck Ext (C1-2)			Hip Flex (L1-2)		
Neck SB (C3)			Hip Ext (S1)		
Scap Elevation (C4)			Hip IR (L2-4)		
Shoulder Flex (C4-5)			Hip ER (L5-S1)		
Shoulder Abd (C5)			Hip Add (L2-4)		
Shoulder			Hip Abd (L4-S1)		
IR (C5-6)			Knee Ext (L3)		
ER (C5-6)			Knee Flex (S2)		
Biceps (C5-6)			PF (S1)		
Triceps (C7-T1)			DF (L4)		
Wrist Ext (C6)			Everson (S1)		
Wrist Flex (C7)			Inversion (L5-S1)		
Thumb Ext (T1)			Toe Ext (L5)		
Intrinsic Hand (T1)			Other		

Sensation_____

Circumference_____

Observation / Posture/ MM Length/Flexibility_____

_____

Palpation_____

_____

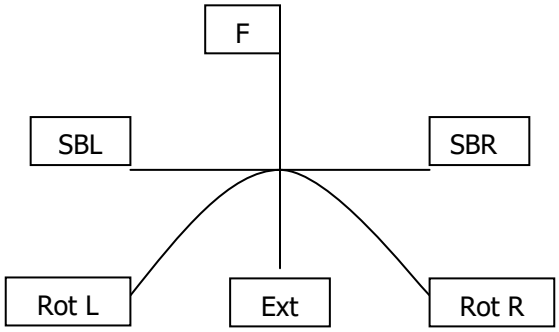
_____

Special Tests / Other _____

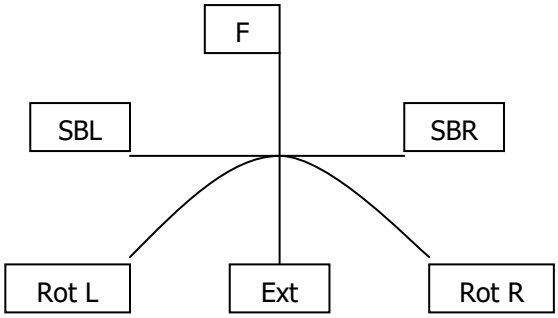
_____

_____

Cervical



Lumbar



Therapist Signature_____ Date_____

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