Mankato Clinic

(Patient Label)

Patient Name:

DOB:

Age:

Date:

OCCUPATIONAL THERAPY QUESTIONNAIRE

What are you being seen for today? _____

Pain: Yes No Where is your pain? _____

Balance issues: Yes No

When did your symptoms begin? _____ **Were your symptoms caused by an injury?** Yes No

Are your symptoms: ___increasing ___ decreasing ___ or staying the same?

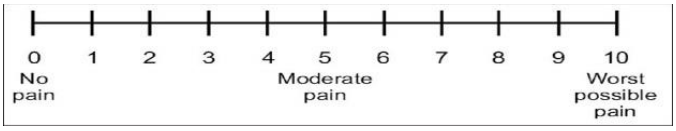
How did your symptoms start? _____ **What aggravates your symptoms?** _____

What relieves your symptoms? _____

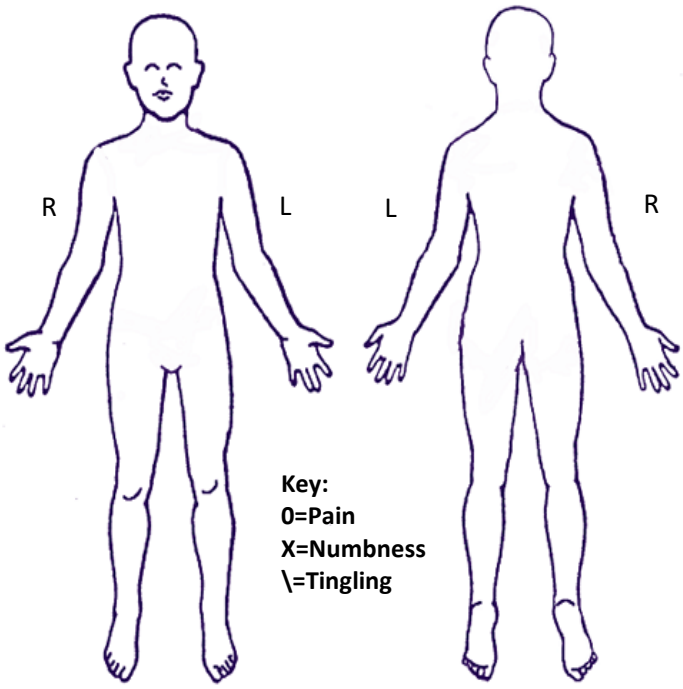
As your day progresses do your symptoms:
___increase ___ decrease ___stay the same?

What is your dominant hand? Left Right

If you are experiencing pain, please rate your pain:



Please use key/diagram to the right to indicate your current symptoms:



How would you describe your symptoms? Check all that apply:

____Aching	____Buckling	____Burning	____Discomfort	____Heavy	____Hot	____Locking
____Motion Loss	____Nauseating	____Numbness	____Pounding	____Punishing	____Sharp	____Stiffness
____Sore	____Swelling	____Throbbing	____Tingling	____Weakness		

What previous treatments have you had for this condition? _____
Have you had any tests done for your condition? Check all that apply: ___CT scan ___X ray ___MRI ___EMG ___Other ____None
At what facility, did you have the tests done?_____
Have you had any falls/near falls? ___ Yes ___ No
Do you use an assistive device for walking (i.e. cane, walker) ___ Yes ___ No

Does your condition cause any limitations? If yes, check all that apply:

____Bending	____Breathing/Coughing	____Driving	____Lifting/Carrying	____Reaching
____Recreation Activities	____Self-Care/Hygiene	____Sitting	____Sleeping	____Squatting
____Stairs	____Standing	____Talking/Chewing/Yawning		____Transitional Movements
____Turning Head	____Typing	____Walking	____Headache if yes, frequency of headaches_____	

Since your symptoms began have you had any of the following? Check all that apply:

____Changes in bowel movements/Bladder	____Chest pain	____Chills/Fever/Nausea/Vomiting	____Cough/Phlegm/Sputum
____Dizziness/Fainting	____Easy Bruising/Bleeding	____Heart Palpitations	____Night sweats/Night pain
____Numbness in genital/anal area	____Problems with vision/Hearing/Speech		____Shortness of breath
____Unexplained weakness	____Unexplained weight change		____Wheezing