Mankato Clinic

(Patient Label)

Patient Name:

DOB:

Age:

Date:

PHYSICAL THERAPY QUESTIONNAIRE

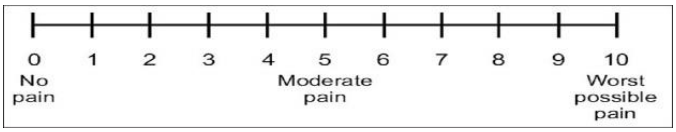
What are you being seen for today? _____

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? _____

If you are experiencing pain, please rate your pain:



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

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		

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

What previous treatments have you had for this condition? _____

BACKGROUND INFORMATION

What is your dominant hand? Left Right
Have you had any falls/near falls? ___ Yes ___ No

How do you learn best? ____Written ____Verbal ____Demonstration ____ other: _____

How many hours of sleep do you get on an average night? ____<6 Hours ____6 – 8 Hours ____>8 Hours
How would you rate the quality of your nutrition/diet? ____Excellent ____Good ____Fair ____Poor

How many days a week do you participate in physical activity? ____<3 Days ____3 – 5 Days ____>5 Days

What forms of physical activity do you participate in? _____

In the last two weeks, have you had little interest or pleasure in doing things? Yes No
In the last two weeks, have you been feeling down, depressed or hopeless? Yes No