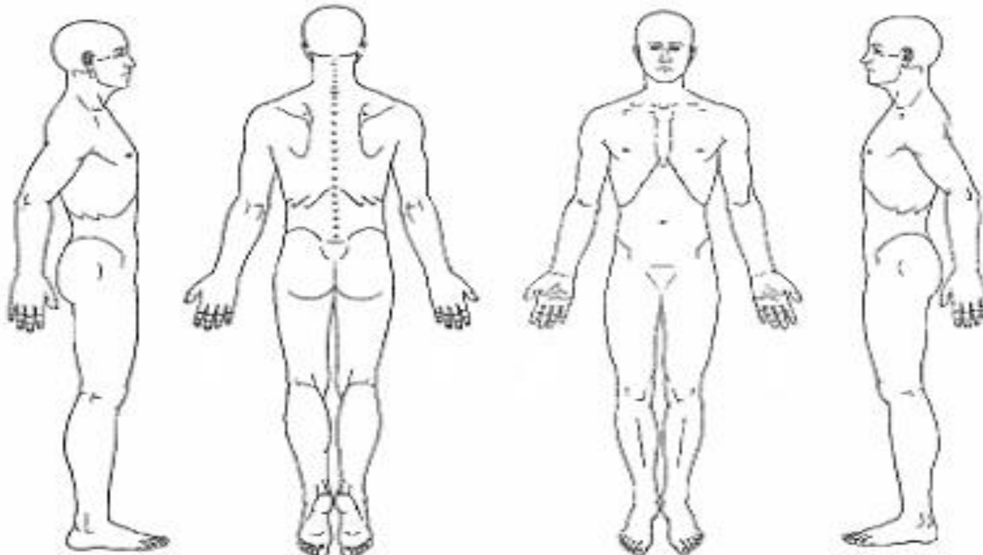
Name:

DOB:

MR#:

Evaluation & Symptom Questionnaire

1. When did your problems begin? ____
2. Briefly describe what occurred:
   ____
3. Have you received therapy for this problem prior to this visit? Yes / No
   If so, When/Where? ____
4. Have you had surgery for this problem? Yes / No
   If so, When/Where? ____
5. What treatments have you had or are still receiving for this problem? ____________________
6. Any test for this problem (MRI, CT scan, EX-ray, etc.)? ______________________________
7. When is your next visit to the Doctor for this problem? _______________________________
8. Are You: (Circle) Employed Retired Student Unemployed
9. (If applicable) Last Day Worked? ______________
10. Job Requirements (Brief Description of what you did):
    ____
11. Where are your symptoms/pain? Write in words or use the picture to mark the affected area(s).
    ____
    ____



12. Circle the words that describe your symptoms or pains.

Aching	Cramping	Hot	Pins & Needles	Tender
Burning	Deep	Itching	Sharp	Throbbing
Cold	Dull	Numbness	Shooting	Tingling
Constant	Heavy	Penetrating	Stabbing	Weak

13. *Do your symptoms or pain occur occasionally, frequently or is it constant? (Circle one)*

Occasionally Frequently Constant

14. *What time of day are your symptoms or pain the worst? (Circle one)*

Morning Afternoon Evening Nighttime

15. *Rate your symptoms by circling the number that best describes the* ***WORST*** *occurrence in the last month.*

None 0 1 2 3 4 5 6 7 8 9 10 As bad as you can imagine

16. *Rate your symptoms by circling the number that best describes the* ***LEAST*** *occurrence in the last month.*

None 0 1 2 3 4 5 6 7 8 9 10 As bad as you can imagine

17. *Please circle the number that best describes your symptoms/pain* ***RIGHT NOW***.

None 0 1 2 3 4 5 6 7 8 9 10 As bad as you can imagine

18. *Do you ever have time without symptoms/pain?* ***YES*** *or* ***NO***

19. *What makes your symptoms* ***BETTER***? ____

20. *What makes your symptoms* ***WORSE***? ____

21. *What treatment or medication are you receiving for your symptoms/pain? If you are not receiving any treatment or medication, circle NONE.*

None
____

22. "Because of this problem, I have trouble with" (Circle all that apply)

Balance	Driving	Lifting	Running	Transfers
Bathing	Endurance	Lying Flat	Sitting	Walking
Bending	Grasping	Performing Job	Sleeping	Yard Work
Carrying	Hopping	Reaching	Squatting	Other__________
Cooking	Housekeeping	Recreational Acts	Stairs	
Dressing	Jumping	Rolling Over	Standing	

23. What is your goal for Therapy? ____

Medical History

Condition	Yes	No	Year	Condition	Yes	No	Year	Condition	Yes	No	Year
Anemia				GI Ulcers				Neuropathy			
Angina				Glaucoma				Parkinson's Disease			
Arthritis				Gout				Phlebitis			
Asthma				Heart Attack				Prostate Disease			
Atrial Fibrillation				Heart Disease				Pulmonary Embolism			
Auto Immune Disorder				Heart Murmur				Recent Weight Loss/Gain			
Back Pain				Hepatitis				Restless Leg Syndrome			
Blood Clots				Hiatal Hernia				Raynaud's Disease			
Cancer				High Blood Pressure				Rheumatic Fever			
Circulation Issues				High Cholesterol				Seasonal Allergies			
COPD				Infectious Disease				STD's			
Depression				Kidney Disease				Stroke (CVA)			
Diabetes				Liver Disease				Thyroid Disease			
DVT				Lung Disease				TIA			
Epilepsy				Migraines				Tuberculosis			
Fibromyalgia				Neck Pain				Use CPAP			
								Do you Smoke			

Any other significant Medical History: ____
____

Please list all current medications (or attach list)

__________________________ __________________________

__________________________ __________________________

__________________________ __________________________

__________________________ __________________________

Patient Signature ___________________________________ Date: ___/ ___/ ________

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Notes:

☐ No action plan required.

☐ Action plan required. See progress note.

Clinician Signature & Professional Designation ___________________________ Date: __/ __/ ____