



Physical Therapy Pre-Exam Questionnaire

In order to evaluate your condition fully, please be as accurate as possible. Thank you.

1. Have you had physical therapy before? Yes No When? _____

2a. Where is your pain or problem? Neck Lower back Middle back Elbow
(check all that apply) Shoulder/upper arm Hip Knee Foot/ankle
 Other: _____

2b. Is it deep or on the surface? Deep On the surface
 2c. Does it move? Yes No
 2d. Does it stay on one place? Yes No

3. Approximately when did it start? ___/___/20___ : How: _____

4. My pain/problem is slowly getting: worse better staying the same

5. My pain bothers me: constantly most of the time only occasionally once in awhile

6. On the scale below circle your worst pain level in the past couple of days:

Mild *Moderate* *Severe*
 0 ... 1 ... 2 ... 3 ... 4 ... 5 ... 6 ... 7 ... 8 ... 9 ... 10

7. What seems to make your pain worse?

8. When it does get worse, how long does it take before calming back down?

9. What seems to make it feel better?

10a. Have you ever had this pain/problem before? Yes No
 10b. If yes, did you receive any treatments at that time? Yes No
 10c. If yes, where?

11a. Do you have any regular numbness or tingling? Yes No
 11b. If yes, where?

12a. Are you taking any medication for this pain/problem? Yes No
 12b. If yes, what and does it help?

13a. Are any of your usual everyday activities affected? Yes No
 13b. If yes, describe how.

14. List all past surgeries with dates:

15. List all medical conditions you have (or were told you have):

Patient Name: _____

Signature: _____ Date: _____