Physical Medicine and Rehabilitation
NEW VISIT - CLINIC QUESTIONNAIRE

Name _____
Medical Record # _____

PERSONAL DATA

1. How do you want our team to address you? (Mr., Ms., first name, nickname) _____

Age: _____ Height: _____ Weight: _____ ☐ Right-Handed ☐ Left-Handed

HISTORY OF CURRENT CONDITION FOR WHICH YOU ARE BEING SEEN

1. When did you first experience the main symptoms you are being seen for today?

_____

2. Did your symptoms come on gradually or suddenly? ☐ Gradually ☐ Suddenly

3. Why do you think these symptoms started (e.g. work injury, fall, accident)?

_____

4. If your injury occurred at work did you file a Worker's Compensation claim and if so, what is the status of the claim?

_____

5. What treatments have you tried for your symptoms? Please check:

☐ Physical therapy ☐ Chiropractic ☐ Acupuncture ☐ Acupressure ☐ TENS
☐ Massage ☐ Biofeedback ☐ Yoga ☐ Hypnosis ☐ Braces
☐ Cane ☐ Walker ☐ Chronic pain program
☐ Other _____

6. Have you had surgery or injections for your condition? ☐ Yes ☐ No
If so, were they helpful? ☐ Yes ☐ No
Please list procedure(s) performed and date(s).

_____

7. Please describe your exercise routine:

_____

8. What medications have you tried for your symptoms? Please list:

_____

_____

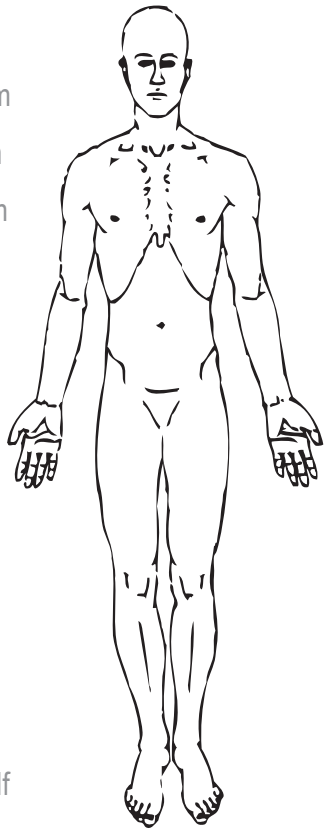
9. Since your symptoms began are they getting: ☐ Better ☐ Worse ☐ Staying the same

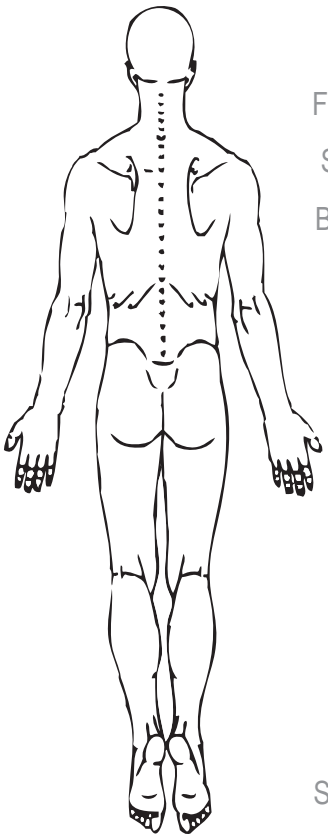
10. Are your symptoms: ☐ There all the time ☐ Do they come and go

11. Please use the check boxes to identify the location(s) of the symptoms we are seeing you for today on the diagrams below:

Left

- ☐ Neck
- ☐ Shoulder
- ☐ Front of upper arm
- ☐ Side of upper arm
- ☐ Back of upper arm
- ☐ Front of forearm
- ☐ Side of forearm
- ☐ Back of forearm
- ☐ Low back
- ☐ Buttock
- ☐ Front of thigh
- ☐ Side of thigh
- ☐ Back of thigh
- ☐ Front of shin
- ☐ Side of shin or calf
- ☐ Top of foot
- ☐ Bottom of foot





Right

- Neck ☐
- Shoulder ☐
- Front of upper arm ☐
- Side of upper arm ☐
- Back of upper arm ☐
- Front of forearm ☐
- Side of forearm ☐
- Back of forearm ☐
- Low back ☐
- Buttock ☐
- Front of thigh ☐
- Side of thigh ☐
- Back of thigh ☐
- Front of shin ☐
- Side of shin or calf ☐
- Top of foot ☐
- Bottom of foot ☐

Comments:

12. Please use the check boxes to describe the pain or sensations you are experiencing:

☐ Dull	☐ Tingling	☐ Throbbing	☐ Shooting
☐ Aching	☐ Pressure	☐ Cramping	☐ Numbness
☐ Sharp	☐ Stabbing	☐ Gnawing	☐ Stiffness
☐ Electrical	☐ Burning	☐ Other _____	

13. Please use the check boxes to rank the severity of pain from 0 (no pain) to 10 (severe pain) you are experiencing:

	0 no pain										10 severe pain
Lowest Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Average Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Worst Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

14. Associated Symptoms:

Do you have any weakness?	☐ Yes	☐ No
Are you dropping things?	☐ Yes	☐ No
Do you have decreased coordination?	☐ Yes	☐ No
Do you have poor walking balance?	☐ Yes	☐ No

15. Pain distribution:
If pain is in region of **neck/arm(s)**, what percentage?____% neck +____% arms =100%

If pain is in region of **back/leg(s)** what percentage? ____ % above waist +____% below waist=100%

16. How long can you do the following activities before your pain limits you?

a. Sit: _____ b. Stand: _____ c. Walk: _____

17. What makes your pain worse? Please check all that apply:

☐ Sitting ☐ Standing ☐ Walking	☐ Twisting at neck or back	☐ Lying down
☐ Bending waist forward or backward	☐ Lifting/Carrying	☐ Pushing/Pulling
☐ Bending neck forward or backward	☐ Climbing Stairs	☐ Descending Stairs
☐ Coughing or sneezing	☐ Working on the computer	☐ Reaching
☐ Other _____		

18. What makes your pain better? Please check all that apply:

- ☐ Backward bending
- ☐ Standing
- ☐ Walking
- ☐ Lying
- ☐ Twisting
- ☐ Forward bending
- ☐ Sitting
- ☐ Medications
- ☐ Ice
- ☐ Heat
- ☐ Exercise
- ☐ Other _____

19. When is your pain at its worst? Specific time of day: _____ With activity: _____

REVIEW OF SYMPTOMS

1. Please check if you have had any of the following in the last 6 months:

- ☐ Difficulty controlling bowel or bladder, please describe: _____
- ☐ Fevers
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Black/Bloody Stool
- ☐ Stomach Pain
- ☐ Easy Bruising
- ☐ Headaches
- ☐ Dizziness/Vertigo
- ☐ Night Sweats
- ☐ Depression
- ☐ Anxiety
- ☐ Urinary Incontinence
- ☐ Other _____

GENERAL MEDICAL HISTORY

1. Please list your current medical problems.

_____

2. Please list any operations you have had and the year performed.

_____

3. Please list the medications you are currently taking.

_____

4. Please list any medication allergies and the reactions you had.

_____

SOCIAL HISTORY

1. Do you smoke? ☐ Yes ☐ No If so, how much? _____
2. Do you drink? ☐ Yes ☐ No If so, how much? _____
3. Do you use drugs? ☐ Yes ☐ No If so, what kind(s) and how often? _____
4. With whom do you live? _____
5. Do you feel safe at home? ☐ Yes ☐ No 6. Marital Status? _____
7. Do you have children? ☐ Yes ☐ No How old? _____
8. Please list present or previous occupation(s):

_____

_____