CORVALLIS SPORT AND SPINE PHYSICAL THERAPY

Orthopedic Initial Questionnaire

Name:

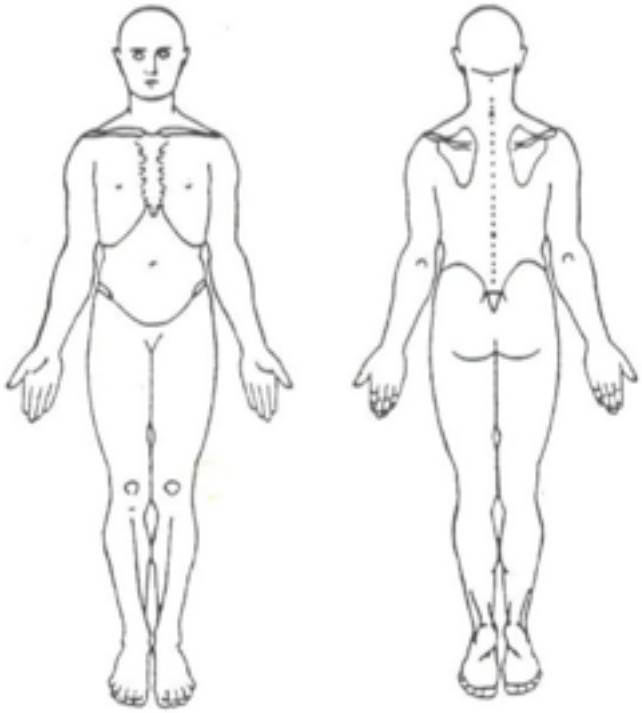
Date:

In order to allow the therapist to have a better understanding of the nature of your injury and evaluate your condition fully, please complete the following questions as accurately as possible. Thank you.

1. When did your symptoms start (date)? _____
2. Briefly describe how your symptoms began or how your injury occurred.

   _____

   _____
3. Date of first doctor's appointment for this injury or for these symptoms. _____
4. Have you had surgery for this injury? ❑ Yes ❑No If yes, when? _____
5. The onset of my symptoms was ❑ Gradual ❑ Sudden
6. What are your symptoms (i.e., pain, numbness, tingling)?



_____

7. **Please mark on the body diagram where your symptoms are.**
8. Type of pain?
   ❑ Sharp ❑ Dull ❑ Throb ❑ Ache ❑ Burning
9. My symptoms have
   ❑ worsened ❑ remained the same ❑ improved
10. My symptoms bother me
    ❑ constantly ❑ most of the time ❑ occasionally
11. My pain over the last few days has been (0-10) _____

12. What makes your symptoms worse? _____

13. What makes your symptoms better? _____

14. Since the onset of this injury, have your noticed any of the following:
    a. Regular numbness or tingling? ❑ Yes ❑ No If yes, where? _____
    b. Bowel/bladder control difficulties? ❑ Yes ❑ No

15. Have you had any imaging of your injury? ❑ Yes ❑ No If yes, when did you have your imaging? _____

❑ Xray ❑ MRI ❑ Bone Scan ❑ CT Scan ❑

Ultrasound

What were the results? _____

16. Have you had this pain or problem before? ❑ Yes ❑ No
If yes,
    a. Did you receive any treatment? ❑ Yes ❑ No If yes, did the treatment help? ❑ Yes ❑ No
    b. What did the treatment consist of? _____

17. What are your goals for physical therapy?
_____
_____

18. Is there anything else about you or your condition that you would like us to know?
_____
_____

Medical History

Allergies	❑Yes ❑No	Depression	❑Yes ❑No	Multiple Sclerosis	❑Yes ❑No
Anemia	❑Yes ❑No	Diabetes	❑Yes ❑No	Osteoporosis	❑Yes ❑No
Anxiety	❑Yes ❑No	Dizzy Spells	❑Yes ❑No	Parkinsons	❑Yes ❑No
Arthritis	❑Yes ❑No	Emphysema/Bronchitis	❑Yes ❑No	Rheumatoid Arthritis	❑Yes ❑No
Asthma	❑Yes ❑No	Fractures	❑Yes ❑No	Seizures	❑Yes ❑No
Cancer	❑Yes ❑No	Gallbladder Problems	❑Yes ❑No	Speech Problems	❑Yes ❑No
Cardiac Conditions	❑Yes ❑No	Hepatitis	❑Yes ❑No	Strokes	❑Yes ❑No
Cardiac Pacemaker	❑Yes ❑No	High Blood Pressure	❑Yes ❑No	Thyroid Disease	❑Yes ❑No
Chemical Dependency	❑Yes ❑No	Incontinence	❑Yes ❑No	Tuberculosis	❑Yes ❑No
Circulation Problems	❑Yes ❑No	Kidney Problems	❑Yes ❑No	Vision Problems	❑Yes ❑No
Currently Pregnant	❑Yes ❑No	Metal Implants	❑Yes ❑No		

Describe any other conditions or precautions. If none, please indicate so. _____
_____
_____

Have you **recently** noticed any of the following?

WEIGHT GAIN/LOSS	❑Y ❑N	FATIGUE	❑Y ❑N	DIZZINESS	❑Y ❑N
NAUSEA/VOMITING	❑Y ❑N	WEAKNESS	❑Y ❑N	FEVER/CHILLS/SWEATS	❑Y ❑N
NIGHT PAIN	❑Y ❑N				

Fall History

Is this injury as a result of a fall in the past year? ❑Yes ❑No Have you had two or more falls in the past year? ❑Yes ❑No

If yes to either, please explain: _____

_____

Surgical History

Body Region: _____ Surgery Type: _____Date: _____/_____/_____

Body Region: _____ Surgery Type: _____Date: _____/_____/_____

Body Region: _____ Surgery Type: _____Date: _____/_____/_____

Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason for Taking: _____

What do you do for recreation? _____

What is your mode of exercise? _____