Questionnaire

Patient Name: _____ Date: _____

Age: _____ Type of Injury: Accident Surgery No specific reason

Imaging Done/Type/Date: _____

PLEASE CIRCLE CONDITIONS THAT APPLY BELOW

Cancer	Anemia	Emphysema	Chest Pain	Incontinence	Metal in Body
DVT	Diabetes	Stroke	Neuropathy	Recent fracture	Hypertension
Heart Condition	Fibromyalgia	Numbness	Hepatitis	Headaches	Pacemaker
TB	Osteopenia	Epilepsy	Depression	Head Injury	Hot/Cold Sensitive
Osteoarthritis	Osteoporosis	CRPS	Blood Clotting disorder	Swelling	
Kidney Disease	Seizures	Asthma	Anxiety	Hearing Loss	Weight Loss/Gain
Gout	Skin disease	Rheumatoid Arthritis		HIV/AIDS	Active Infection

Past Orthopaedic Surgeries: _____

Pain level 0-10 (0 is no pain, 10 is the most excruciating pain you've ever felt)

Current Pain level: 0 1 2 3 4 5 6 7 8 9 10

High in past week Pain Level: 0 1 2 3 4 5 6 7 8 9 10

What improves pain: _____

What makes pain worse/positions: _____

Current Symptoms: _____

MEDICATIONS (Prescriptions)

MEDICATION NAME	DOSAGE	FREQUENCY	ROUTE(ORAL/INJ./TOPICAL)

Additional Information:

Focused Physical Therapy
10750 Columbia Pike, Suite #310 ♦ Silver Spring, Md 20901
P 301-658-6353 ♦ F 301-576-4550