

South Aiken Physical Therapy Orthopedic Pre-Exam Questionnaire

To expedite the admissions process, please respond in detail and as accurately as possible

1. What is your age? _____
2. Do you live.... Alone With family Other: _____
3. At the present time, would you say your health is excellent, very good, fair or poor? _____
4. What is your occupation? _____
- Are you working now? Yes No
5. During the past 2 weeks, how much has your problem interfered with your normal work and housework?
 Not at all A little bit Moderately Quite a bit Extremely
Describe how _____

6. Do you play sports or have active hobbies? Yes No
If yes, what and how often? _____
7. Do you now have, or had in the past..... Diabetes High Blood Pressure
 Cancer Heart Conditions Neuropathy
8. List all other medical conditions you have (or were told you have)? _____

9. Are you taking any medication for this pain/problem? Yes No
- If yes, what and does it help? _____

10. List any relevant past surgeries with dates: _____

11. When was your most recent X-ray? ____/____/20____
When was your most recent MRI? ____/____/20____
Any other special tests for this?

If you had surgery for this problem, answer below, otherwise skip to next page.

12. What type of surgery did you have?
When was the surgery? ____/____/20____
Why did you need surgery?

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13. Where is your pain or problem? Neck Lower back Middle back Hip Knee
 Foot/ankle Wrist/Hand Elbow Shoulder/upper arm Other:

13a) My pain is..... Deep On the surface

13b) My pain.... Stays in one place Moves to _____

13c) What best describes the nature of your symptoms? Sharp Dull Ache Numb
 Shocking Burning Tingling

13d) Do you have any regular numbness or tingling? Yes No

14. When did this problem first begin? ____/____/20____ (approximate date)

15. How did it start?

How has it changed since then?

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

17. My pain bothers me.... all of the time most of the time some of the time once in a while
I have pain.... At night when I get up with basic daily tasks at the end of the day

18. On a scale from 1 to 10 (see below), what is the worst your pain has been in the past 2 weeks? ____/10
Best it has been? ____/10 What is your usual pain with typical daily activity? ____/10

<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>
0 ... 1 ... 2 ... 3 ... 4 ... 5 ... 6 ... 7 ... 8 ... 9 ... 10		

19. What activity or positions seem to make your pain worse?

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

20. What seems to make it feel better?

21. Have you had physical therapy before for this problem? Yes No
If yes, where and when? _____

22. What are your main goals of recovery? (Please be specific)

Patient Name

Signature (Parent/Guardian if patient under 18)

____/____/20____
Date