Comprehensive Physical Rehabilitation Services

920 Colloredo Blvd.
Shelbyville, TN 37160

PATIENT QUESTIONNAIRE –SPINE

Date:_____ Name:_____ Age:_____ Referring Dr._____

Occupation:_____ Is this work related? Yes/No

Are you presently working? Full time/ Part time With Restrictions? Yes/No

Have you experienced problems of this type before? (Explain)_____

Current symptoms begin? Date:_____ How did your symptoms arise? Auto, Accident, Fall,

Bending, Lifting, No Apparent Reason, Other (Describe)_____

_____

What are your symptoms NOW? Back symptoms only Neck symptoms only Headache
Leg symptoms only Arm symptoms only
Back and Leg symptoms Neck and arm symptoms

What were you INITIAL symptoms? Back symptoms only Neck symptoms only Headache
Leg symptoms only Arm symptoms only
Back and Leg symptoms Neck and Arm symptoms

Are your symptoms constant in your (Circle one) (Back, Leg, Neck, Arm)
OR do they come and go in your (Circle one) (Back, Leg, Neck, Arm)

Are your symptoms improving, becoming worse, or staying the same?_____

Circle the daily activities you are having trouble doing: Sitting, Rising, Bending, Driving, Standing, Turning, Walking, Stairs, Lying, Sleeping, Grooming, Dressing, Housework, Athletics etc._____

Circle the activities that decrease your symptoms: Sitting, Lying, Standing, Walking, Bending, Turning, Being Stationary, Moving.

Do your symptoms disturb you sleep? Yes/No # times per night awakened by pain?_____

Do your symptoms change when you Cough, Sneeze, Strain? Yes/No

Do you have frequent: Headaches, Dizziness, Nausea, Ear Ringing, Balance Disturbance, Other?_____

Have you noticed a change in your bowel or bladder frequency control? Yes/No (Describe):_____

Who have you consulted regarding this injury? Emergency room MD, Family Dr., Specialist

What treatment or testing have you received? X-ray, MRI, Cat Scan, Myelogram, Nerve Conduction Study, Physical Therapy, Chiropractic, Medication, Injection, Bracing, Orthotics, Other: (Describe):_____

_____

If surgery date and type?_____When do you return to see the doctor that referred you to therapy?_____

Health Concerns? Heart, Hypertension, Stroke, Epilepsy, Cancer, Diabetic, Respiratory Disorder, Pregnancy, Metal Implants, Pacemaker, Other:_____

Are you allergic to Latex, Lidocain, Cortisone, Other?_____

List all current prescriptions and over the counter medication and reason for use:_____

_____

_____

What are your goals for physical therapy? Decrease Pain, Improve Function, Return to Exercise/Athletics

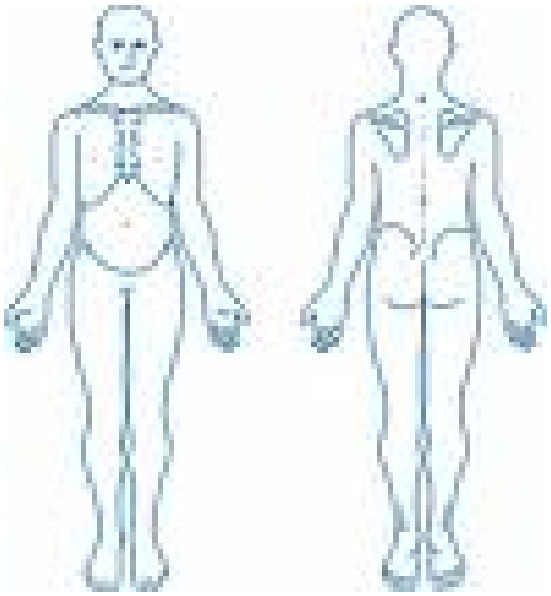
Other:_____

On a pain scale from 0 to 10 please state your pain level: 0 being normal and 10 severe (ER):

Back:_____ Neck:_____ Leg:_____ Arm:_____

Please use the following words and indicate on the diagram where your feel the described symptom.

Aching: Numbness: Pins and Needles: Burning: Stabbing: Other:



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Attending Physical Therapist