Comprehensive Physical Rehabilitation Services

920 Colloredo Blvd.
Shelbyville, TN 37160

PATIENT QUESTIONNAIRE –EXTREMITY

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,

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

_____

Who have you consulted regarding this injury? Emergency room MD, Family Doctor, Specialist.
(Describe):_____

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

If surgery date and type?_____

When do you return to see the doctor who referred you to therapy? Date and time:_____ Time:_____

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 prescription and over the counter medications or ask front desk to make a copy of your current medications:_____

Do you participate in a regular exercise/sport program: Yes/No (Describe):_____

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

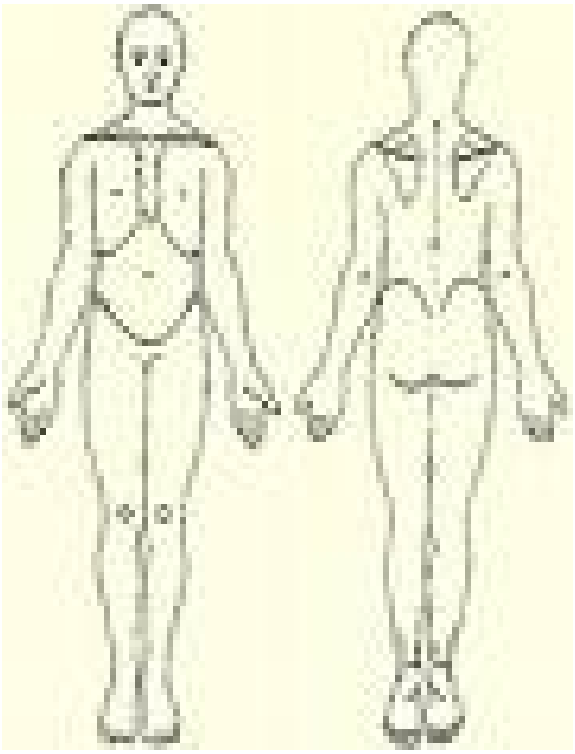
_____

_____

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

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

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



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Attending Physical Therapist