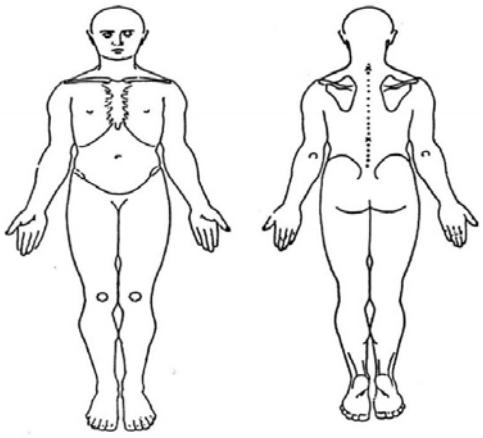
FYZICAL Therapy & Balance Centers

Physical Therapy Pre-Exam Questionnaire

In order to evaluate your condition fully, please be as accurate as possible. Thank you.

1a. Where is your pain or problem? Place an "X" in the area or areas where you are experiencing pain/symptoms.



1b. Is it deep or on the surface? ☐ Deep ☐ On the surface
1c. Does it move? ☐ Yes ☐ No
1d. Does it stay on one place? ☐ Yes ☐ No
1e. What kind of pain? ☐ Severe ☐ Moderate ☐ Dull ☐ Throbbing ☐ Burning ☐ Stabbing
☐ Radiating or shooting ☐ Numbness/ Tingling ☐ Stabbing ☐ Sharp ☐ Weakness ☐ Other

Please rate your pain from 0 (no pain) to 10 (worst imaginable pain) at

Worst	0	1	2	3	4	5	6	7	8	9	10
Now	0	1	2	3	4	5	6	7	8	9	10
Best	0	1	2	3	4	5	6	7	8	9	10

1f. Have you ever had
- Balance problems? ☐ Yes ☐ No
- Lightheadedness? ☐ Yes ☐ No
- Dizziness? ☐ Yes ☐ No
- Vertigo? ☐ Yes ☐ No

1g. Do you have any history of falls?
Have you had any fall (2 or more) in the past year? ☐ Yes ☐ No
If yes, did you have any injury? ☐ Yes ☐ No
When was your last fall? _____

1h. Do you have <u>any</u> fear of falling? ☐ Yes ☐ No

2a. Have you ever had this pain/balance issue before? ☐ Yes ☐ No

2b. If yes, have you received any treatment in the past 12 months for this or any problem? ☐ Yes ☐ No

2c. If yes, when and where?

3. Approximately when did the pain or balance issue start? ___ /____/20___ : What initially caused it?

4. My pain/balance is slowly getting: ☐ worse ☐ better ☐ staying the same

5. My pain/balance bothers me: ☐ constantly ☐ most of the time ☐ only occasionally ☐ once in awhile

6. What seems to make your pain or balance worse? (What activity, position(s) or movement(s) that causes more pain?)
☐ Sitting ☐ Standing ☐ Lifting ☐ Bending ☐Other _____

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7. How much does your pain/problem interfere with your **Daily Activities**?

None 20% 40% 60% 80% 100% of the day.

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

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

10. Have you had any **diagnostic tests** related to this problem? (i.e. MRI or X-rays) ☐ Yes ☐ No
Where and when:

11. List all past **surgeries** with dates:

12. Check all medical conditions you have (or were told you have):

☐ Anemia ☐ Allergies ☐ Asthma ☐ Back Pain ☐ Bowel / Bladder Issues (Incontinence)
☐ Cancer ☐ Chest Pains ☐ Depression ☐ Diabetes ☐ Disc Problems ☐ Headaches
☐ Dizziness / Fainting ☐ Epilepsy ☐ Excessive Fatigue ☐ Fever, Higher than 100 Degrees F
☐ Heart Attack ☐ Heart Disease ☐ High Blood Pressure ☐ Hypoglycemia ☐ Infectious Disease
☐ Knee Pain ☐ Kidney Problems ☐ Liver / Gallbladder Problems ☐ Low Blood Pressure
☐ Low Exercise Level ☐ Metal Implants ☐ Nausea / Vomiting ☐ Neck Pain ☐ Neck Stiffness
☐ Open Wounds ☐ Osteoarthritis ☐ Osteoporosis ☐ Pacemaker or Defibrillator
☐ Perforated Ear Drums ☐ Radiation Treatment within the last 3 months
☐ Rheumatoid Arthritis ☐ Ringing In Ears ☐ Seizures ☐ Shortness Of Breath/Difficulty Breathing
☐ Skin Rashes ☐ Stomach or Intestinal Issues ☐ Stroke ☐ Thyroid Problems
☐ Tingling In Arms / Hands ☐ Tingling In Legs / Feet ☐ Typhoid/cholera/dysentery ☐ Vision Problems
☐ Seizures ☐ Other Health Issues (please explain)

13. What **medications** are you currently taking? (Prescription, over-the-counter, Vitamins, Supplements, Herbals)

Medication	*Dosage*	*Frequency*

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14. In your understanding, what do you think will make you better?
15. How optimistic are you that you'll get better? (circle one) Not at all Mildly optimistic Fairly Very optimistic Extremely optimistic
16. What are some potential obstacles to you getting better?
17. Over the next month, how many hours per week will you commit to getting better?
18. What are you expecting from your Physical Therapy program?

Patient Name:_____

Signature:_____ Date: _____