Pain / Injury Questionnaire

Name: _____

- Describe how this started: _____
  _____
  _____
- How long have you had your current symptoms? _____

If working, list 2-3 specific activities that are difficult to do because of your current condition.
If not working, list 2-3 specific activities that you anticipate being difficult when you return.

- _____
- _____
- _____

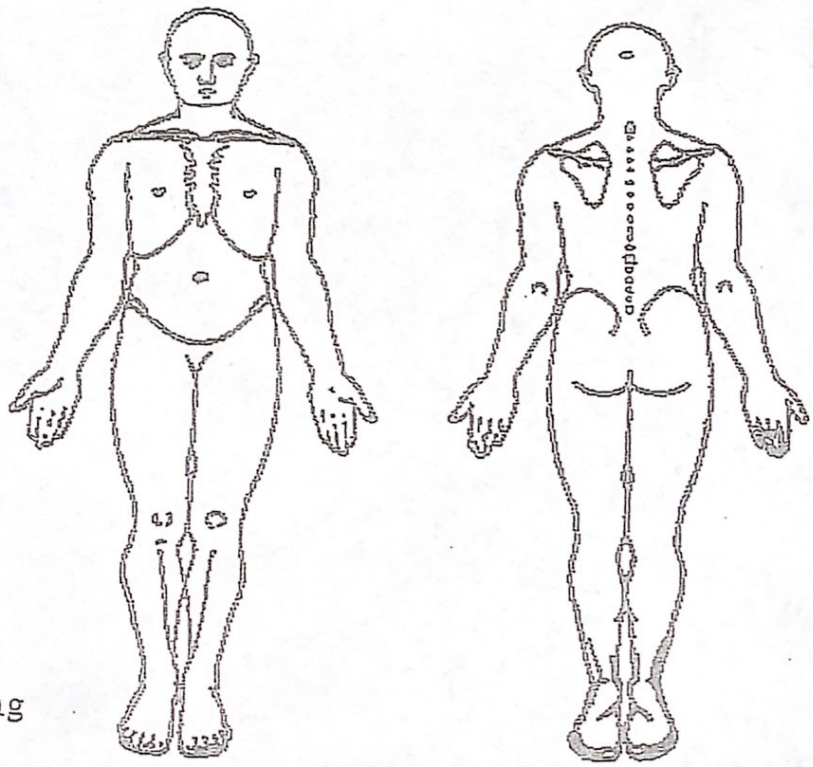
If off of work, when do you expect to return to work? _____

- Apart from work, list 2-3 specific daily activities that are difficult because of your current condition.
  - _____
  - _____
  - _____
- Do you feel your symptoms are ☐ improving ☐ worsening ☐ not changing?
- What specifically makes your pain worse? _____
- What helps to reduce your pain? _____
- Rate your pain between 0 - 10

____ pain level NOW
____ WORST pain over last 24 hours
____ BEST over last 24 hours

0 = no pain
3 = your pain restricts mobility or range of motion
8 = you would go to the hospital
10= worst pain imaginable

- Have you had similar problems before? ☐ No ☐ Yes, Number of previous episodes: ☐ 1-5 ☐ 6-10 ☐ 11+
- What treatments have you tried? _____
- Does your condition interrupt your sleep? ☐ No ☐ Yes, how many hours of uninterrupted sleep? _____
- Have you had an ☐ x-ray ☐ MRI ☐ CTscan ☐ Injection ☐ Other test _____
- List 2 realistic goals you would like to accomplish while in physical therapy (please be specific)?
  - _____
  - _____
- Please draw your symptoms:



= Pain

= Spasm / Tightness

= Numbness / Tingling