White Mountain Physical Therapy Questionnaire

Name: _____ **Date:** _____

Reason for today's visit? _____

When did this problem begin, or recently become worse? _____

What helps to alleviate your current problem? _____

What makes it worse? _____

How frequent are the symptoms experienced? Constant or Intermittent

What tests have you had for this complaint? (Circle what applies)

X-ray CAT scan MRI Myelogram Bone Scan

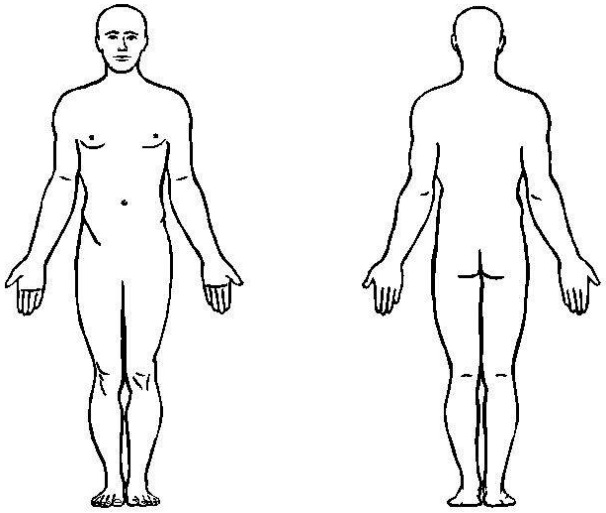
Please circle on the line below your current pain level.

None _____Pain Level_____High
1 2 3 4 5 6 7 8 9 10

Please circle the symptoms that you are experiencing with this problem:

Swelling	Loss of balance	Tingling
Loss of motion	Numbness	Weakness
Other _____		

Please mark an X on the body diagram where the pain is the worst →



Is this problem work related? Yes or No

If "Yes", your employer's name:

_____

Your Occupation: _____

Work Status: _____

Continue on back →

About your general health…

___ High Blood Pressure
___ Diabetes
___ Cancer
___ Heart Murmurs
___ Rheumatic Fever
___ Unusual Cardiac Findings
___ Unusual Shortness of Breath
___ Vitamin B Deficiencies
___ Pregnant If "Yes", due date _____
___ Peripheral Vascular Disease
___ Asthma
___ Emphysema
___ Bronchitis
___ Chest Discomfort
___ Phlebitis, Emboli, Deep Vein Thrombosis
___ Extreme Fatigue or Tiredness
___ Pacemaker or Metal Implant
___ Other _____

Please explain in detail if any of the above applied: _____

_____

Current Medication	Dose (mg)	Taken How Often?	Route of Administration

Do you have any drug allergies? Yes or No

If yes, please indicate type of allergy: _____

Do you smoke? Yes or No How much? _____

Current quality of sleep: (Circle one) Good, Slightly disturbed or Poor

Have you recently been ill or hospitalized? Yes or No
If yes, please indicate type of illness: _____

_____

Please list any surgeries you have had in the last 12 months: _____

_____

_____

Have you received any other treatment for this complaint? (Circle which applies)
Previous Physical Therapy Chiropractic Alternative Medicine Injections

Specify: _____

_____