



Physical Therapy Pre-Exam Questionnaire

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

1. Have you had **Physical therapy** within the last 12 months? Yes No
Chiropractor within the last 12 months? Yes No
2. What **caused** your pain/problem? _____
3. Approximately **when** did it start? _____ / _____ /20_____
4. Is it getting **worse, better, or staying the same?** _____
5. Have you ever had this pain/problem **before?** Yes No
6. Have you had any **imaging** (x-ray, MRI, etc.) for this problem? Yes No
7. Are any of your daily activities affected? Yes No
 - If yes, **describe** (i.e. dressing, sitting, walking, sleeping, work duties, recreational, etc.)

8. Check all **medical conditions** that you have and list any additional ones:

- | | |
|--|---|
| <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Cancer (specify: _____) | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Circulation problems (specify: _____) | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart problems (specify: _____) | <input type="checkbox"/> Other (specify: _____) |

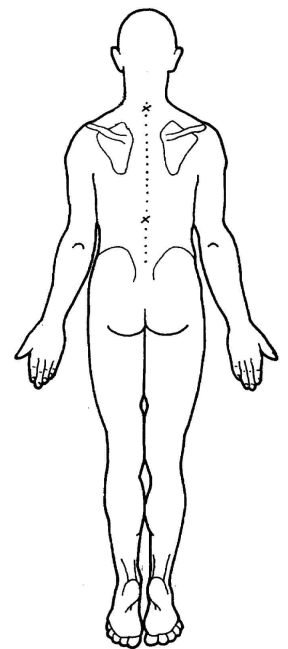
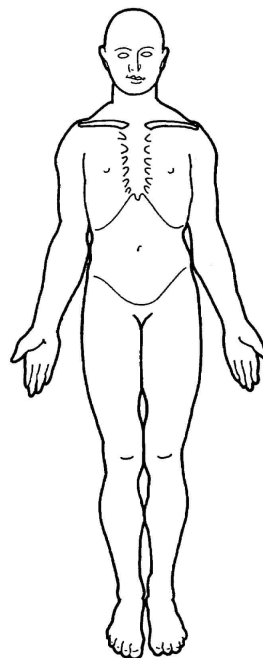
9. List **all medications** you are currently taking:

10. List **all past/present surgeries** with date (mm/yyyy):

Body Chart

Please mark the area(s) where you feel your symptom(s)

Pain	X X X
Stiffness	/ / /
Swelling	o o o
Numbness/ Tingling	= = =



Patient Name: _____

Signature: _____

Date: _____