Carling Aquatic and Physical Therapy Initial Evaluation

Pre-Exam Questionnaire

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

1. What is your age? _____

2. What is your gender? ☐ Male ☐ Female

3. What is your occupation? _____
   * Are you working now? ☐ Yes ☐ No

4. Have you had previous physical therapy? ☐ Yes ☐ No

5. Where is your pain/problem? _____

6. What caused your pain/problem? _____

7. Approximately when did it start? _____

8. Is it getting worse, better or staying the same? _____

9. Have you ever had this pain/problem before? ☐ Yes ☐ No

10. Is your pain constant (never goes away)? ☐ Yes ☐ No

11. On the scale below, circle your worst pain level in the past couple of days:

    Mild Moderate Severe

    0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10

12. Are you taking any medication for this pain/problem? ☐ Yes ☐ No
    * If yes, what and does it help? _____

13. Are any of your usual everyday activities affected? ☐ Yes ☐ No
    * If yes, describe how. _____

14. List all your past surgeries with dates: _____
_____

15. List all medical conditions you have (or were told you have): _____

Patient Name: _____

Signature: _____ Date: _____