Thunder Bay Therapy & Sports Medicine

Patient Symptom Questionnaire

Name: ____ **DOB:**__________________ **Date:**_________________________

1. Date of injury/onset of symptoms:____

2. Describe the body area involved: ____
____

3. How would you describe your injury?

□ Lifting
□ Car accident
□ A fall
□ Running
□Trauma
□ Degeneration
□ During sports/recreation
□ Cumulative trauma/overuse
□ Unknown
□ Other: ________________
____

4. Where did your injury occur?(e.g., Home, parking lot, etc.)____

5. What caused your symptoms?
____
____

6. Nature of symptoms (check all that apply):

□ Sharp
□ Dull
□ Aching
□ Continuous
□ Throbbing
□ Burning
□ Radiating
□ Tingling
Other:_______________________
____
____
____

7. Which best describes the intensity of your pain:

□ 0. **No symptoms**
□ 1. **Minimal.** Can be ignored.
□ 2. **Minimal to mild.** Noticeable during daily tasks
□ 3. **Mild**. Annoying and noticeable during daily tasks.
□ 4. **Mild to moderate** requiring medication on occasion.
□ 5. **Moderate**. Requires meds, sleep disturbed and daily tasks hindered
□ 6. **Moderate to severe.** Irritable sleep, avoiding <75% of tasks.
□ 7. **Severe.** Unable to perform daily tasks or work duties
□ 8. **Severe.** Unable to perform bathing, toileting. Requires partial bed rest. Assistance required to leave home.
□ 9. **Total bed rest.** May pass out.
□ 10. Call the ambulance.

8. What makes your symptoms worse? (Check all that apply)

□Time of day: _________________
□ Position:____________________
□ Sitting
□ Moving to/from sitting
□ Standing
□ Squatting
□ Walking
□ lying down
□ Coughing/sneezing
□ Taking a deep breath
□ Sustained bending
□ Chewing
□ Swallowing
□ Sleeping
□ Reaching overhead
□ Reaching behind back
□ Looking up
□ Up/down stairs
□ Up/down an incline
□ Sports/recreation
□ Stress
□ Vacuuming
□ Doing dishes
□Making the bed
□Other:______________________
____

9. Does the pain wake you at night? □ Yes, ____times/night □ No

10. What relieves your symptoms? (Check all that apply)

□ Sitting
□ Standing
□ Lying down
□ Changing positions
□ Rest
□ Alcohol
□ Exercise
□ Heat
□ Cold
□ Stretching
□ Massage
□ Medication
□ Nothing
□ Other_____________

11. What previous treatment have you had? (Check all that apply)

□ Physical therapy
□ Exercise
□ Prescription medication
□ Over the counter medication
□ Injection
□ Massage Therapy
□ TENS unit
□ Traction
□ Manipulation (chiropractic or osteopathic)
□ Bracing/taping
□ None
□ Other:______________________

12. Have you had imaging/testing? □ X-rays □ EMG □ MRI □ CT scan □ Arthrogram □ Other_____________

13. Have you had any operations on the body region associated with your present symptoms: □ No □Yes
Date:__________________ Procedure:____

14. Are you currently working?

□ Yes, Full time □ Yes, Part time □ Yes, restricted duty □ No □ Retired (skip to question 16)
Occupation: ____

15. What are the physical requirements of your job?

□ Standing
□ Bending
□ Sitting
□ Lifting: _________________lbs.
□ Walking
□ Other:______________________

16. Please list any activities that you cannot do now due to your symptoms:

____
____
____

17. What are your goals for therapy?

____
____
____

18. Have you had Physical, Occupational or Speech Therapy in the last 60 days? □ Yes □ No

Thunder Bay Therapy & Sports Medicine

Medical Systems Review

Name:____________________________________ DOB:__________________ Date:___________________

Are you latex sensitive? □ Yes □ No

Do you have a pacemaker? □ Yes □ No

Do you smoke? □ Yes: _____Packs per day □ No

Women – Are you pregnant? □ Yes □ No

Have you recently noticed any of the following? (check all that apply)

□ Fatigue
□ Fever/chills/night sweats
□ Unexpected Weight loss
□ Fainting/Dizziness
□ Nausea/Vomiting
□ Diarrhea
□ Coughing
□ Abdominal pain
□ Constipation
□ Heartburn/indigestion
□ Difficulty swallowing
□ Falls/ Loss of balance
□ Headaches
□ Muscle weakness
□ Bleeding/bruising easily
□ Nail bed changes
□ Urine color changes
□ Concussion
□ Infection
□ Skin changes
□ Changes in bowel/bladder function
□ Other:________________________
____
____

Have you ever been diagnosed with any of the following? (check all that apply)

□ Cancer
□ Heart/cardiac problems
□ Chest pain/Angina
□ High blood pressure
□ Osteoarthritis
□ Rheumatoid arthritis
□ Diabetes
□ Osteoporosis
□ Parkinsons
□ Blood clots
□ Ulcers
□ Kidney disease/Infection
□ Asthma
□ Pneumonia
□ Spina Bifida
□ Depression
□ Lung problems
□ Tuberculosis
□ GERD/Gastrointestinal problems
□ Circulation/Vascular problems
□ Other arthritic changes
□ Bladder/Urinary tract infections
□ Hepatitis/Liver disease
□ Sexually transmitted disease/HIV
□ Lupus
□ Thyroid problems
□ Multiple sclerosis
□ Epilepsy
□ Stroke
□ Anemia
□ Bone or joint infection
□ Alcoholism
□ Drug dependency
□ Other:_________________________
____
____

What surgeries have you had in the past? Please list with approximate dates.

____
____
____
____

During the past month, have you been feeling down or depressed? □ Yes □ No

Do you feel safe in your home? □ Yes □ No

Medications

Medication Name	Prescribed Purpose	Medication Name	Prescribed Purpose