Pain Questionnaire

Name: ____ Date: ________________

Please answer the following questions about your condition:

When did you notice the pain growing or begin to have functional limitations due to the pain?

____

How did your symptoms begin (what were you doing?)

____

Was the pain sudden or a gradual onset?

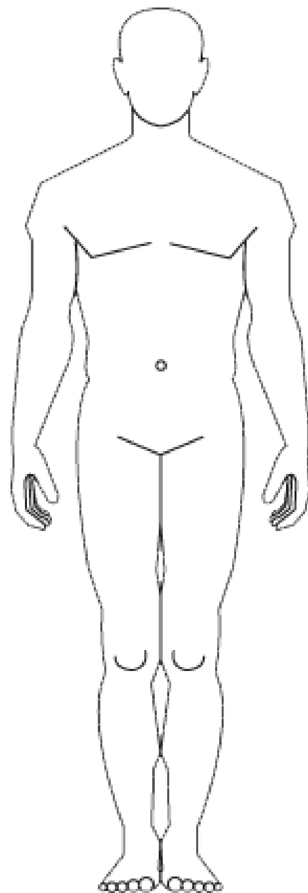
____

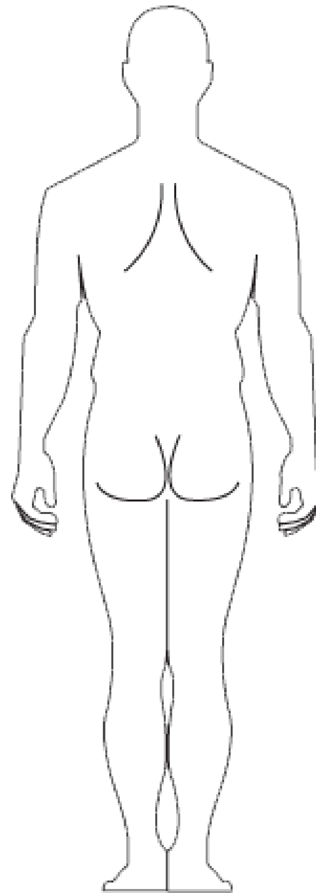
What are two functional goals you would like to achieve?

1. ____ 2.____

Please mark on the diagram where your symptoms are located using the symbols below

= Numbness + Tingling *Sharp/Shooting pain))) Swelling ^^^ Dull ache





Please indicate your level of pain on the following scale with 0 being no pain and 10 being the worst pain.
<u>Please write a number for each.</u>

___Currently

___With Activity

___ At rest

___Worst in last month

___ Least in last month

Are your symptoms currently? Please <u>check</u> at least one.

___ Worse

___ Better

___ Same

___Constant

___ Intermittent

***Your insurance company may require us to take periodic height/weight measurements. ***

Are you currently taking any medications? If so, please list.

____

____

____

INFORMED CONSENT TO PHYSICAL THERAPY (PT): Prior to treatment, patient acknowledges understanding and has been advised of condition, assessment, treatment risks/benefits with/without treatment, proposed alternatives, and patient goals. Patient understands exercises programs, activities modifications or treatment in PT may be part of the treatment plan. Patient agrees to fully participate in program. Repeated cancellations may result in program discontinuation. Patient consents to recommended PT treatment plan.

PT Initials ____________ Patient Signature ____