



Physical Therapy & Wellness Center

## PRE-EXAM QUESTIONNAIRE

**1** What is your goal? (i.e. why are you here? What activities would you like to return to? Etc..)

---

---

**2** Do you have pain or a physical condition which is currently limiting you? Yes No

**2a** When did this problem/pain first begin?

\_\_\_\_\_ *approximate date*

**3** Did you have surgery for your problem? Yes No

If yes, date of surgery: \_\_\_\_\_ Surgery type: \_\_\_\_\_

Surgery performed by: \_\_\_\_\_

**4** How did your pain/problem start?

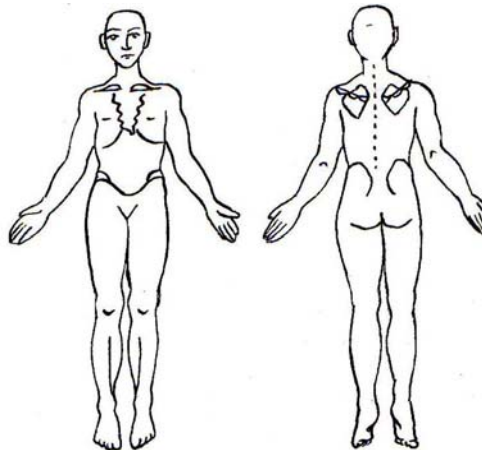
---

---

**5** Where is your pain/problem & what type of pain did you experience?

*(please indicate on the chart using the key to label your symptoms)*

- 1. Radiating Pain
- 2. Numbness/Tingling
- 3. Dull Ache
- 4. Sharp Pain
- 5. Shooting Pain
- 6. Burning
- 7. Increased Sensitivity
- 8. Weakness
- 9. Swelling
- 10. Other



**5a** Do you have any regular numbness or tingling? Yes No

**5b** Do you have pain with coughing or sneezing? Yes No

**5c** Do you experience headaches or dizziness? Yes No

**5d** Sudden, unexplained weight loss? Yes No

On a scale from 1 to 10, what is the worst your pain has been in the past several days?

Mild discomfort      Moderate      Unbearable/Severe

1    -----    5    -----    10

6 My pain bothers me  constantly  most of the time  once in a while

7 What seems to make your pain/problem worse? \_\_\_\_\_  
\_\_\_\_\_

8 What seems to make it feel better? \_\_\_\_\_  
\_\_\_\_\_

9 List the dates and results of any Xrays or MRI's: \_\_\_\_\_  
\_\_\_\_\_

10 Do you exercise on a regular basis?      yes    no  
If yes, describe your workout: \_\_\_\_\_  
\_\_\_\_\_

11 Check and/or list all medical conditions you have or have had:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> High Blood Pressure                 | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Muscle Cramps      |
| <input type="checkbox"/> Diabetes                            | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Fractures                           | <input type="checkbox"/> Chronic Illness       | <input type="checkbox"/> Chronic Fatigue    |
| <input type="checkbox"/> Seizures                            | <input type="checkbox"/> Asthma                | <input type="checkbox"/> Osteoporosis       |
| <input type="checkbox"/> Arthritis                           | <input type="checkbox"/> Dizzy spells/fainting | <input type="checkbox"/> Joint replacement  |
| <input type="checkbox"/> Pace Maker                          | <input type="checkbox"/> Shortness of Breath   | <input type="checkbox"/> Pace Maker         |
| <input type="checkbox"/> Currently Pregnant or Breastfeeding |  |   |
| <input type="checkbox"/> Other: _____                        |  |   |

12 Are you currently taking any medications (If yes please list)? \_\_\_\_\_  
\_\_\_\_\_

13 Any additional information you would like us to know?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date