PT-Form G

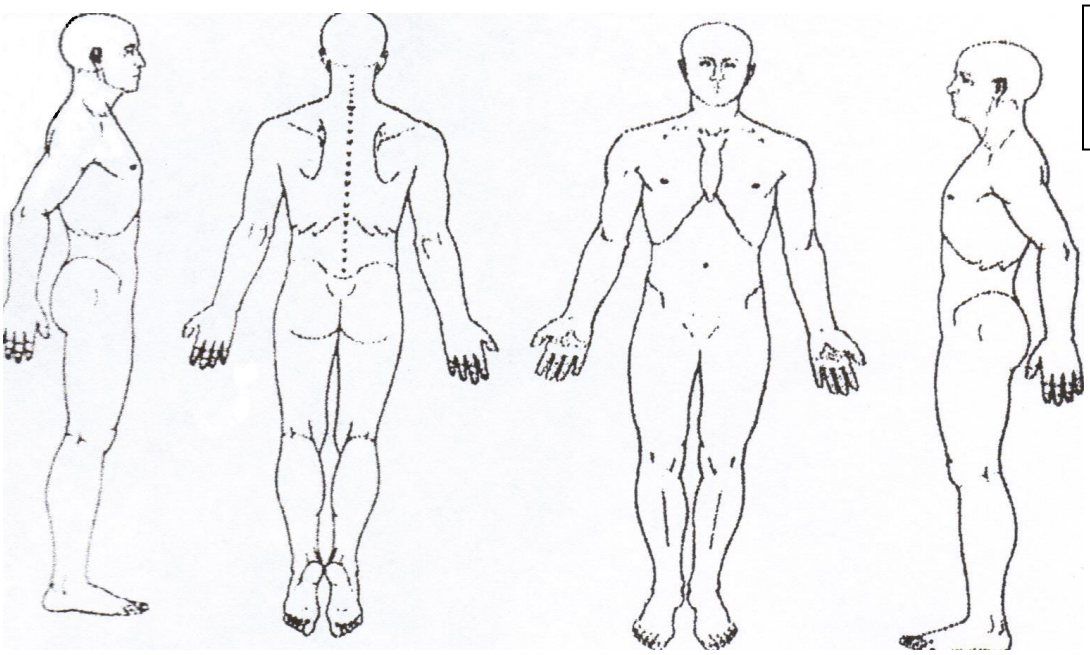
OTTAWA COUNTY HEALTH CENTER
PHYSICAL THERAPY QUESTIONNAIRE

Patient Name _____ **Date** _____

Please describe your current complaint/symptom_____
How did your symptoms begin?_____
When did your symptoms start? (specific date if possible)_____

How often do you experience your symptoms?
☐ constant (76-100%) ☐ frequent (51-75%) ☐ occasional (26-50%) ☐ Intermittent (25% or less)

Please indicate on the body diagram, using the pain symbols, where you have pain.



/ / /	STABBING
XXX	BURNING
OOO	PINS & NEEDLES
-----	NUMBNESS
+++	ACHING

Please **circle** your pain rating at **its lowest and highest**, then place an **'X' over your current pain level.**

0 1 2 3 4 5 6 7 8 9 10
No pain — Emergency room

Your symptoms are ☐ getting better ☐ not changing ☐ getting worse

Your symptoms are worse in ☐morning ☐afternoon ☐night ☐increased during day ☐same all day

Have difficulty with or can't perform: ☐Mobility: Walking & Moving Around ☐Self Care
☐Changing & Maintaining Body Positions ☐Other_____
☐Carrying, Moving & Handling Objects ☐N/A

What are your goals for therapy?_____
In the past, have you been treated for the same or similar problem? ☐Yes ☐No
If yes, what treatment did you receive?_____
Did this treatment help?_____

During the past month, how much of the time has your condition interfered with your social activties?
☐ all of the time ☐ most of the time ☐ some of the time ☐ a little of the time ☐ none of the time

During the past month, how much has pain interfered with your normal work(outside the home and housework)
☐ not at all ☐ a little bit ☐moderately ☐quite a bit ☐extremely

In general, would you say your overall health right now is ☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

Occupation_____**Has your work status changed because of this condition?** Y / N
Describe job duties _____