BODY-N-BALANCE

3005 Old Alabama Road, Building E, Johns Creek, Georgia 30022

T 770.552.8852 F 770.552.8481

www.body-n-balance.com

PHYSICAL THERAPY QUESTIONNAIRE

BIRTHDATE ___________

NAME: ____
LAST FIRST MIDDLE INITIAL

How did you hear about us? ____

Referring Physician: ______________________________ ( ) ______________
NAME PHONE NUMBER

Describe the problem for which you are seeking treatment: ______________________________

____

____

When did the problem begin? ____

____

____

Have you received any treatment for the problem? (circle one) Yes No

If yes, what type of treatment? ____

____

____

List any prescription medication, over the counter medication, vitamins, or supplements that you are presently taking:

____

____

Are you allergic to any medications? (circle one) Yes No

If yes, please list those medications: ____

____

List type and date of any previous surgery: ____

____

____

Do you have any metal implants or pins? (circle one) Yes No

Have you had any unexplained weight gain or weight loss in the past month: (circle one) Yes No

Do you smoke? Yes No If yes, how many packs a day? ___________ How many years? ___________

Do you drink alchohol? (circle one) Yes No

How much caffeine do you consume a day (coffee, tea, softdrinks, etc)? __________

For Females Only: Are you pregnant or is there any possibility that you might be pregnant? Yes No

Have you ever been diagnosed with?

	Yes		No	
Cancer Type: __________	Yes	______	No	______
Heart Problems:				
High Blood Pressure	Yes	______	No	______
Coronary Heart Disease	Yes	______	No	______
Heart Attack	Yes	______	No	______
Congestive Heart Failure	Yes	______	No	______
Peripheral Vascular Disease	Yes	______	No	______
Thrombophlebitis	Yes	______	No	______
Pace Maker	Yes	______	No	______
Respiratory Problems:				
Asthma	Yes	______	No	______
Emphysema	Yes	______	No	______
Chronic Bronchitis	Yes	______	No	______
Rheumatoid	Yes	______	No	______
Other: __________	Yes	______	No	______
Osteoporosis	Yes	______	No	______
Stroke	Yes	______	No	______
Diabetes	Yes	______	No	______
Anemia	Yes	______	No	______
Multiple Sclerosis	Yes	______	No	______
Kidney/Bladder Problems	Yes	______	No	______
Epilepsy	Yes	______	No	______
Chemical Dependency	Yes	______	No	______
Depression	Yes	______	No	______
Migraine Headaches	Yes	______	No	______

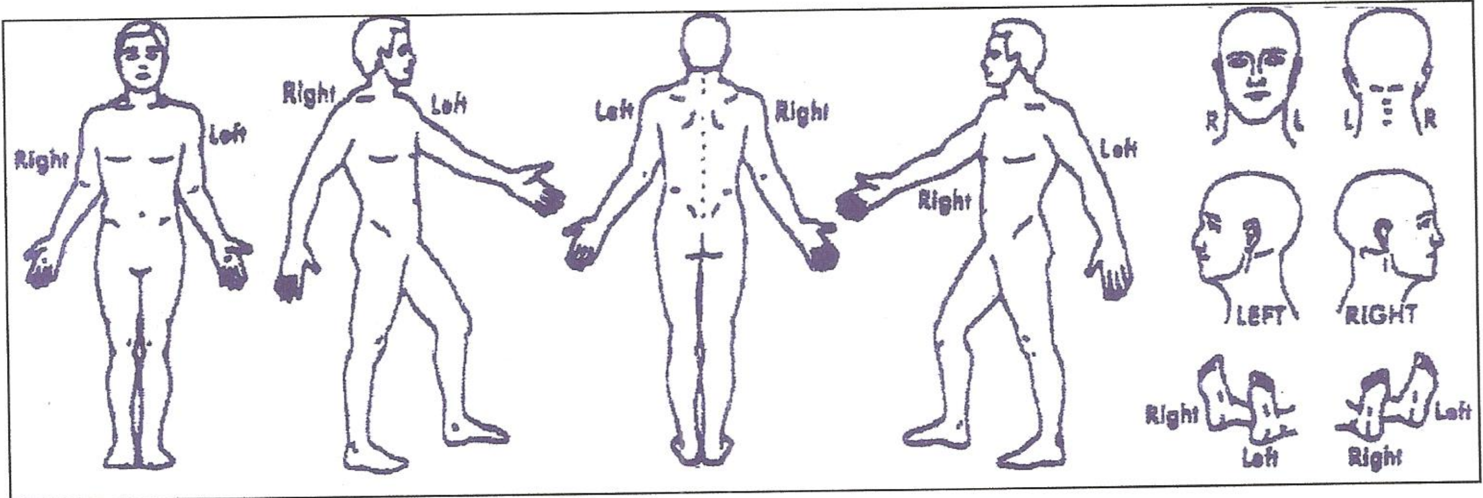
Other (please list): ______________________________

Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain.

////////////// Stabbing XXXXXXX Burning ▇▇▇▇ Numbness OOOOOO Pins&Needles ΛΛΛΛΛ Aching

Check other descriptions of your pain that apply:

_______ Cramping _______ Pressure _______ Throbbing _______ Cutting



What causes or increases the pain? (check all that apply)

_______ Sitting _______ Standing
_______ Walking _______ Bending
_______ Reaching _______ Up Stairs
_______ Pushing _______ Pulling
_______ Housework _______ Yardwork
_______ Driving _______ Dressing
_______ Bathing _______ Other _______________

What relieves the pain? (check all that apply)

_______ OTC Meds
_______ Prescription Meds
_______ Heating Pads
_______ Cold Packs/Ice
_______ Bath/Shower

Change in position:

_______ Sit
_______ Stand
_______ Walk

Please list at least three important activities that you are unable to do or are having difficulty with as a result of your problem & rate them using the scale below.

0	1	2	3	4	5	6	7	8	9	10
Able to perform activity										Inability to perform activity

Activity	Initial Date							
1								
2								
3								
Total Perceive of Disability								

TOTAL _______________

THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE AND I UNDERSTAND THAT IT WILL REMAIN CONFIDENTIAL.

_______________________________ SIGNATURE OF ADULT PATIENT/PARENT/LEGAL GUARDIAN

_______________ DATE