



ALBANY SPORT & SPINE PHYSICAL THERAPY

Orthopedic Initial Questionnaire

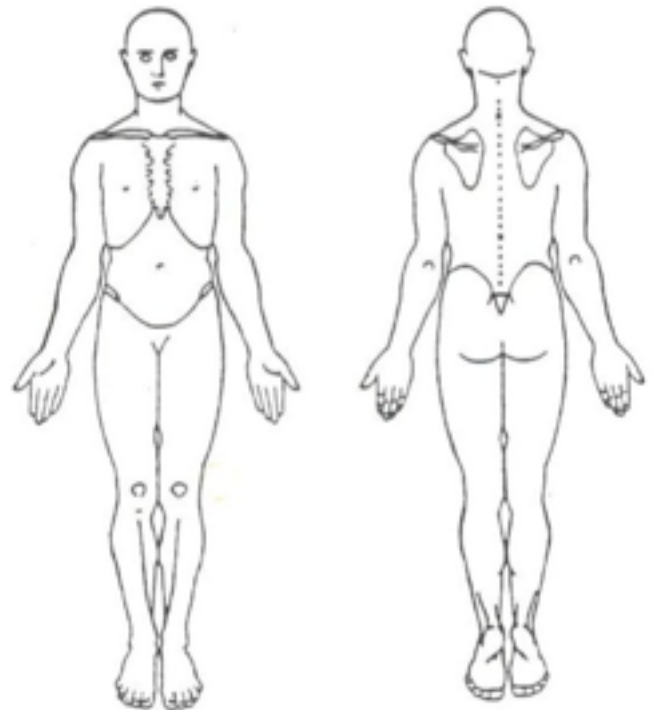
Name: _____

Date: _____

In order to allow the therapist to have a better understanding of the nature of your injury and evaluate your condition fully, please complete the following questions as accurately as possible. Thank you.

1. When did your symptoms start (date)? _____
2. Briefly describe how your symptoms began or how your injury occurred.

3. Date of first doctor's appointment for this injury or for these symptoms. _____
4. Have you had surgery for this injury? Yes No If yes, when? _____
5. The onset of my symptoms was Gradual Sudden
6. What are your symptoms (i.e., pain, numbness, tingling)?



7. Please mark on the body diagram where your symptoms are.

8. Type of pain?
 Sharp Dull Throb Ache Burning
9. My symptoms have
 worsened remained the same improved
10. My symptoms bother me
 constantly most of the time occasionally
11. My pain over the last few days has been (0-10) _____

12. What makes your symptoms worse? _____
13. What makes your symptoms better? _____
14. Since the onset of this injury, have you noticed any of the following:
- a. Regular numbness or tingling? Yes No If yes, where? _____
 - b. Bowel/bladder control difficulties? Yes No
15. Have you had any imaging of your injury? Yes No If yes, when did you have your imaging? _____
- Xray MRI Bone Scan CT Scan

Ultrasound

What were the results? _____

16. Have you had this pain or problem before? Yes No
- If yes,
- a. Did you receive any treatment? Yes No If yes, did the treatment help? Yes No
 - b. What did the treatment consist of? _____

17. What are your goals for physical therapy?

18. Is there anything else about you or your condition that you would like us to know?

Medical History

Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinsons	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema/Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gallbladder Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Strokes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulation Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Currently Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Metal Implants	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Describe any other conditions or precautions. If none, please indicate so. _____

Have you **recently** noticed any of the following?

- | | | | | | |
|------------------|---|----------|---|---------------------|---|
| WEIGHT GAIN/LOSS | <input type="checkbox"/> Y <input type="checkbox"/> N | FATIGUE | <input type="checkbox"/> Y <input type="checkbox"/> N | DIZZINESS | <input type="checkbox"/> Y <input type="checkbox"/> N |
| NAUSEA/VOMITING | <input type="checkbox"/> Y <input type="checkbox"/> N | WEAKNESS | <input type="checkbox"/> Y <input type="checkbox"/> N | FEVER/CHILLS/SWEATS | <input type="checkbox"/> Y <input type="checkbox"/> N |
| NIGHT PAIN | <input type="checkbox"/> Y <input type="checkbox"/> N | | | | |

Fall History

Is this injury as a result of a fall in the past year? Yes No Have you had two or more falls in the past year? Yes No

If yes to either, please explain: _____

Surgical History

Body Region: _____ Surgery Type: _____ Date: ____/____/____

Body Region: _____ Surgery Type: _____ Date: ____/____/____

Body Region: _____ Surgery Type: _____ Date: ____/____/____

Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason for Taking: _____

What do you do for recreation? _____

What is your mode of exercise? _____