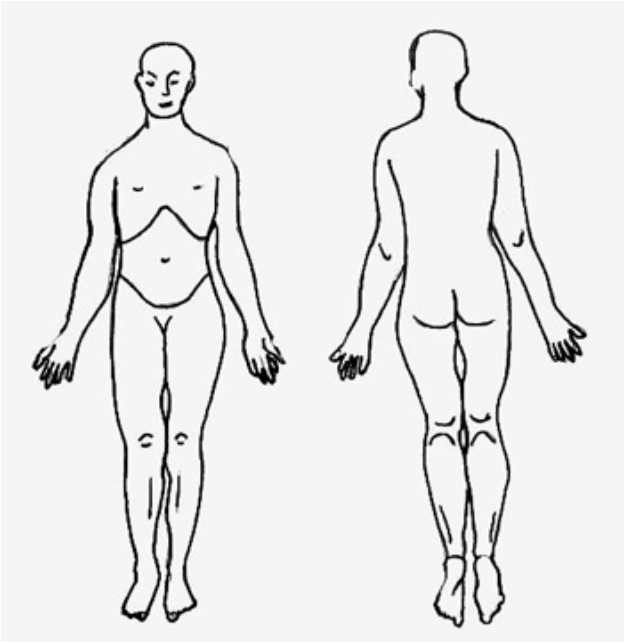
Patient Name _____ Date of Birth ____/____/_____

Advanced Rehabilitation Clinics
Physical Therapy Pre-Exam Questionnaire

Please indicate the location of your symptoms on the body diagram below:



Briefly describe your symptoms:

□ Aching □ Constant
□ Sharp/Stabbing □ Intermittent
□ Numbness □ Burning
□ Tingling □ Other _____

On the scale below, circle your **worst** pain the last couple of days:

Mild *Moderate* *Severe*
0 1 2 3 4 5 6 7 8 9 10

On the scale below, circle your **best** pain the last couple of days:

Mild *Moderate* *Severe*
0 1 2 3 4 5 6 7 8 9 10

What caused your pain/or problem? _____

Approximately when did it start? ____/____/_____

Is it getting worse, better, or staying the same? _____

Have you ever had this pain/problem before? (Circle) YES NO

Are any of your usual everyday activities affected? YES NO
If yes, describe how:

List all past surgeries with dates:

List all medical conditions you have (or were told you have):

Please provide a list of all your current medications. (A photocopy of a printed list is acceptable).

_____ _____
Patient Signature Date