Physical/Occupational Therapy Pre-Exam Questionnaire

In order to evaluate your condition fully, please be as accurate as possible. Thank you.

1. **What is your age?** ______
2. **What is your gender?** ☐ Male ☐ Female
3. **What is your occupation?** ____________________
   - Are you working now? ☐ Yes ☐ No
4. **Have you had physical/occupational therapy before?** ☐ Yes ☐ No
5. **Where is your pain/problem?** ____________________
6. **What caused your pain/or problem?** ____________________
7. **Approximately when did it start?** ___/___/20____
8. **Is it getting worse, better, or staying the same?** ____________________
9. **Have you ever had this pain/problem before?** ☐ Yes ☐ No

---

10. **Is your pain constant (never goes away)?** ☐ Yes ☐ No
11. **On the scale below circle your worst pain level in the past couple of days:**

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

12. **Are you taking any medication for this pain/problem?** ☐ Yes ☐ No
    - If yes, what and does it help?
13. **Are any of your usual everyday activities affected?** ☐ Yes ☐ No
    - If yes, describe how.

---

14. **List all past surgeries with dates:**

15. **List all medical conditions you have (or were told you have)?**

Patient Name:______________________________

Signature:______________________________ Date:__________

Initial Evaluation

Physical/Occupational Therapist Initials____