UWMC Questionnaire – Outpatient Physical Therapy

Name: __________________________________  Occupation: ________________________________

Reason for seeking therapy: ____________________________ Date of onset: ______________________

What do you want to accomplish during therapy?
__________________________________________________ ______________________________________

Please mark the areas of pain or problem:

Check the symptoms that describe your abnormal sensation.

☐ Weakness  ☐ Stiffness  ☐ Lightheadedness  
☐ Swelling  ☐ Dizziness  ☐ Unsteady Walking
☐ Numbness  ☐ Pain  ☐ Unsteady Standing  
☐ Other: ________________________________

If you have pain, check the description that is most appropriate:

☐ Sharp  ☐ Throbbing  ☐ Aching  ☐ Burning
☐ Stabbing  ☐ Heavy  ☐ Dull
☐ Other: ________________________________

Circle the number corresponding to the intensity of your pain or other symptoms:

No Pain---0---1---2---3---4---5---6---7---8---9---10---Worst Pain

Does pain wake you up at night? ☐ No ☐ Yes, how often? ______  Average hours of sleep per night: ______

What increases your symptoms? Check all that apply.

☐ Lying Down  ☐ Sitting  ☐ Standing  ☐ Walking  ☐ Running  ☐ Stairs  ☐ Hills  ☐ Jumping
☐ Reaching Overhead  ☐ Pushing  ☐ Pulling  ☐ Lifting  ☐ Squatting  ☐ Kneeling  ☐ Throwing
☐ Bending Forward  ☐ Coughing/Sneezing  ☐ Stress/Anxiety  ☐ Other: ________________________________

What improves your symptoms?
__________________________________________________

What studies have you had for this problem? Check all that apply.

☐ X-rays  ☐ CT  ☐ MRI  ☐ EMG (nerve study)  ☐ Arthrogram  ☐ Bone Scan

List any surgeries, hospitalizations, and injuries (fractures, dislocations, sprains) related to this issue.

Surgery: ______________________ Date: ________  Surgery: ______________________ Date: ________

Injury: ______________________ Date: ________  Injury: ______________________ Date: ________

Hospitalization: ______________ Date: ________  Hospitalization: ______________ Date: ________
Medical History

- Arthritis
- Balance Problems
- Bowel/Bladder Problems
- Cancer
- Chest Pain
- Depression/Anxiety/Panic
- Diabetes
- Dizziness/Fainting
- Heart Disease
- Hepatitis
- High Blood Pressure
- HIV/AIDS
- Nausea/Vomiting
- Osteoporosis/Osteopenia
- Pregnancy
- Shortness of breath
- Stroke
- Unusual fatigue or weakness
- Vision Problems
- Connective Tissue Disorders
- Dizziness/Fainting

Other

Do you have: a pacemaker? □ Yes □ No    Any metal implants? □ Yes □ No    If yes, where? ___________

Do you have any allergies? □ Yes □ No    If yes, please list any medications, foods, latex, adhesive, or iodine.

Please list all medications you are currently taking. ____________________________________________

__________________________________________

Home Environment

I live in a: □ House/Condo    □ Apartment    □ Adult Family Home    □ Retirement Home/Independent
□ Retirement Home/Assisted Living    □ Other: ____________

I live with: □ Alone    □ Spouse/Significant    □ Child/Children    □ Group Setting    □ Other: ____________
□ Hired Help/Caregiver: List number of hours ____________

How many stairs to enter your home? _______ Handrail(s): □ Yes □ No

How many stairs within your home? _______ Handrail(s): □ Yes □ No

Do you use: □ Cane    □ Walker    □ Wheelchair Manual    □ Wheelchair Power    □ None

Falls History

Approximately how many falls have you had in the past year? ____________Past 3 years? ________

Have you sought medical attention in the past year because of a fall? □ Yes □ No

Are you worried about falling? □ Yes □ No

If yes, describe types or causes of your falls (rushing, tripping, curbs, turns, etc.)

__________________________________________

Do you have problems with your balance or feel unsteady on your feet? □ Yes □ No

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