UWMC Questionnaire – Outpatient Physical Therapy

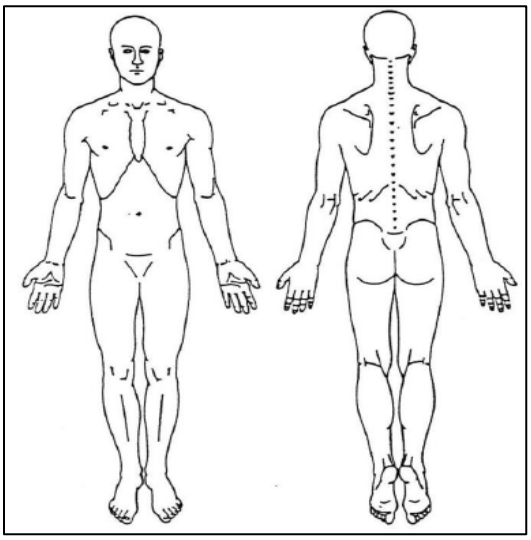
Name: _____ **Occupation:** _____

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: _____

PLACE PATIENT LABEL HERE

Medical History

____Arthritis	____Epilepsy/Seizures	____Osteoporosis/Osteopenia
____Balance Problems	____Headaches	____Pregnancy
____Bowel/Bladder Problems	____Heart Disease	____Shortness of breath
____Cancer	____Hepatitis	____Stroke
____Chest Pain	____High Blood Pressure	____Unusual fatigue or weakness
____Depression/Anxiety/Panic	____HIV/AIDS	____Vision Problems
____Diabetes	____Nausea/Vomiting	____ Connective Tissue Disorders
____Dizziness/Fainting	____Numbness/Tingling	

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

PROVIDER SIGNATURE	PRINT NAME AND TITLE	DATE	TIME

PLACE PATIENT LABEL HERE