# Client Questionnaire:

Client Information:

<table>
<tr><td colspan="2">Name:</td><td colspan="2">Date:</td></tr>
<tr><td>Handedness: (Circle) R / L</td><td>Gender: (Circle) M / F</td><td>DOB:</td><td>Age:</td></tr>
<tr><td colspan="4">Occupation:</td></tr>
<tr><td colspan="4">Working Status: (Circle) Don’t work Disability/Leave Part Time Full Time</td></tr>
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Today’s Visit:

| **What brings you in today? What are you experiencing?** |
|---|
| **When did your symptoms start?** (date, month, compared to today) |
| **How did your symptoms start?** (injury, surgery, over time, etc.) |
| **When your symptoms started were they…:** (Circle)<br>Gradual or Sudden First Time or Recurrence |

Pain:

| **Do you have any PAIN related to what brings you in?** YES or NO<br>**(If YES,** please fill out this pain table**)** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Please circle your pain on a scale from 0 - 10 for below.** 0 = NO pain, 10 = unbearable | | | | | | | | | | | |
| **Now in the present:** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Worst in the past week:** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Best in the past week:** | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Where is the pain located on your body body?** (be as specific as you can) | | | | | | | | | | | |
| **Does your pain travel or stay in one place?** | | | | | | | | | | | |
| **Describe your pain?** | | | | | | | | | | | |

Symptoms/Complaints:

| **What makes your symptoms worse?** | | | | |
|---|---|---|---|---|
| **What makes your symptoms better?** | | | | |
| **At what time during the day is it the worst?** | Morning | Afternoon | Evening | Night |
| **Do your symptoms affect your sleep?** | | Yes | No | |

| **Since onset, have your symptoms gotten…** | Better | Worse | Same |
|---|---|---|---|
| **Have you sought other treatments for this?** (PT, Chiropractor, Acupuncture, Massage, Injections, etc.) **If so, was it helpful?** | | | |
| **Are you currently receiving any treatment?** | | | |
| **Have you had any diagnostic tests or imaging for your current complaints?** (CT scan, X-ray, MRI, EMG, ultrasound, Bone scan, etc) | | | |

**Do you experience any of the following *WITH* your current complaints?**

*(check all boxes that apply):*

- ❏ Numbness and/or tingling in hands or feet
- ❏ Changes to bowel and/or bladder function
- ❏ Slurring of speech
- ❏ Memory changes
- ❏ Changes to weight and/or appetite
- ❏ Intolerance to hot/cold temperatures
- ❏ Changes to skin (rash, discoloration, temperature, etc)
- ❏ Sudden muscle weakness
- ❏ Tiredness/fatigue
- ❏ Changes to exercise tolerance
- ❏ Gait changes
- ❏ Shortness of breath
- ❏ Headaches
- ❏ Persistent joint pain
- ❏ Vision changes
- ❏ Fainting spells
- ❏ Dizziness and/or Vertigo
- ❏ Nausea and/or Vomiting
- ❏ Fever, Chills, and/or Sweats
- ❏ Problems with coughing and sneezing
- ❏ Bruising or bleeding disorders
- ❏ Difficulty sleeping

Activity:

| **Activity level *BEFORE*?** | Sedentary | Lightly Active | Active | Very Active |
|---|---|---|---|---|
| **Activity level *NOW*?** | Sedentary | Lightly Active | Active | Very Active |

| **What are your hobbies and daily activities?** |
|---|
| **Does your symptoms affect your daily function, job, activity level, hobbies, etc?** (If YES, please list out.) |

Medical History:

| **Allergies:** (please specify) | | |
|---|---|---|
| **List all current medications and supplements:** | | |
| **List any past surgeries, injuries, accidents:** (please include time frame) | | |
| **Are you pregnant?** (females) | Yes | No |
| **Do you have a pacemaker?** | Yes | No |
| **Have you fallen in the past year?** | Yes | No |
| **Frequent loss of balance in the past year?** | Yes | No |

| **Do you drink alcohol?** | Yes | No | Occasionally |
|---|---|---|---|

| **Do you smoke tobacco?** | Yes | No | Occasionally |
|---|---|---|---|
| **Do you participate in recreational drugs?** | Yes | No | Occasionally |
| **Height:** _______feet ______inches | **Weight**: ____________lbs. | | |

Do you have any of the following in your medical history?
*(check all boxes that apply):*

- ❏ Hypertension
- ❏ Chest pain/angina
- ❏ Heart disease
- ❏ Stroke
- ❏ Seizures
- ❏ Diabetes
- ❏ Osteoporosis
- ❏ Arthritis
- ❏ Rheumatoid arthritis
- ❏ Cancer
- ❏ Headaches/Migraines
- ❏ Hypothyroid
- ❏ Hyperthyroid
- ❏ Depression
- ❏ Anxiety
- ❏ DVT
- ❏ Cellulitis
- ❏ Lymphedema
- ❏ GERD
- ❏ Obesity
- ❏ Falls
- ❏ Fractures
- ❏ Low Back Pain
- ❏ Pneumonia
- ❏ CVI
- ❏ Difficulty hearing
- ❏ Vision impairments
- ❏ Learning disabilities
- ❏ Asthma
- ❏ Neuropathy

**Client Signature:____________________________________________ Date:_______________________**

**Form has been read and reviewed by therapist: Yes No PT Initials:___________**