

# 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:  

<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>
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: \_\_\_\_\_