TOTAL BODY physical therapy
EXPERTS IN MOTION

PATIENT PAIN AND FUNCTION QUESTIONNAIRE

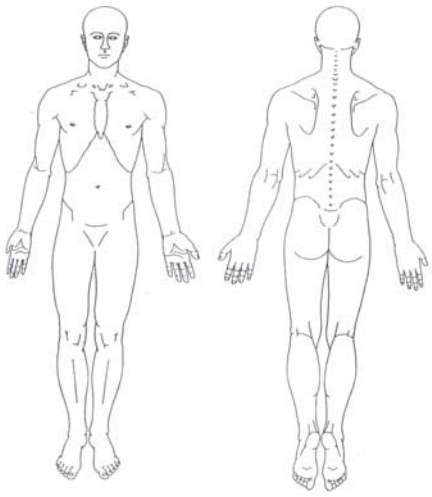
Personal:

1. Are you working? Yes No Occupation:_____
2. If no, when was the last time you worked: _____
3. List the physical demands as of the last time you worked or your current occupation.
   _____
4. List any significant past medical history that we need to know about:
   _____
   _____
5. List any medications you currently take (i.e. birth control pills, anti-inflammatories, muscle relaxants, pain medications, heart medication, diabetes medication, etc).
   _____
   _____
   _____

Reasons for your appointment:

1. Your main complaint or problem:
   _____
2. On a scale of 0 to 10, rate your pain today.
   (0—no pain; 10—most severe)
   0 1 2 3 4 5 6 7 8 9 10
3. Please use the body diagram to the right to show any areas of discomfort. Use these symbols below:

   ||| = shooting pain
   …. = ache
   /// = pain
   xxx = numbness
   ~~~ = constant ache



4. What positions/activities increase your pain?
   _____
5. What positions/activities decrease your pain?
   _____
6. What functional skills are you unable to do now?
   - How long can you sit w/o pain?
   - How long can you stand w/o pain?
   - How far can you walk w/o pain?
   - How well do you sleep?
   - Dressing?
   - Bathing?
   - Use stairs?
   - Reach Overhead?
   - Squat/Stoop/Lift?
   - Other?
7. What specific job activities do you have difficulty performing?
   _____
8. What recreational activities do you have difficulty performing?
   _____

Previous Treatment

1. What tests/treatments have you had for this problem?
   _____
2. What other health care providers have you seen? (i.e. orthopedist, dentist, chiropractor, etc.)
   _____
3. Are you or could you possibly be pregnant? Have you recently been pregnant?
   _____
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