Medfield
orthopedic
& sports
Therapy

QUESTIONNAIRE (To be reviewed with your therapist)

Name__________________________________Date of IE________

DOB______________age_______height__________weight_______

Check the box which corresponds to your answer(s):

1. What body part you are being seen for:

☐ Lower Back ☐ Mid Back ☐ Back/posture

☐ Neck ☐ Shoulder ☐ Hip/pelvis

☐ Ribs ☐ Elbow ☐ Wrist ☐ Hand

☐ Foot/heel ☐ Knee ☐ Ankle

2. Which side of the body:

☐ Both ☐ Right ☐ Left

3. Which is your dominant hand:

☐ Right ☐ Left

4. Who have you seen so far for this problem:

☐ PCP ☐ ER ☐ Orth ☐ Neuro

☐ Other MD ☐ DPM ☐ Chiropractor

☐ Massage Therapist ☐ Other__________

5. Check what tests you have had so far and <u>underline</u> any you are scheduled to have: ***please ask the office where the testing was done to fax us the written report to 508-359-9115.***

☐ None ☐ X-ray ☐ CT scan

☐ MRI ☐ Bloodwork

6. When did this problem start _____/_____/_______

☐Sudden onset ☐Gradual increase in symptoms

☐Traumatic injury ☐Chronic problem that flared up

7. How were you injured/how symptoms occurred:

☐ Deconditioning (side effect of other medical issues)

☐ Slip & fall ☐ Work ☐ Fall (from height)

☐ Sports ☐ Growth problem ☐ Posture problem

☐ Car accident ☐ Repetitive use

8. Other body parts you have injured before:

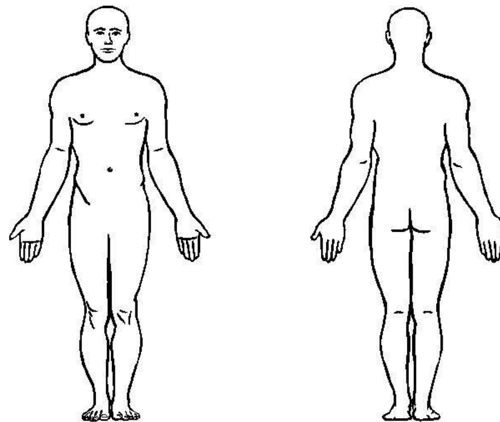
☐ Back ☐ Neck ☐ Shoulder

☐ Elbow ☐ Wrist ☐ Hand

☐ Foot/heel ☐ Knee ☐ Ankle

☐ Ribs ☐ Hip/pelvis

9. Mark where you feel your symptoms:



10. Rate your pain on a scale of 1-10 (circle your #)
(0 = no pain, 1-3 = mild, 4-6 = moderate, 7-9 = severe, 10 = worst pain you've ever had)

Past 24 hours (on average):
0 1 2 3 4 5 6 7 8 9 10

Best it gets:
0 1 2 3 4 5 6 7 8 9 10

Worst it gets:
0 1 2 3 4 5 6 7 8 9 10

Current:
0 1 2 3 4 5 6 7 8 9 10

11. Pain symptoms you currently experience:

☐ Dull/achy ☐ Sharp ☐ Shooting

☐ Burning ☐ Tingling ☐ Numbness

12. What makes the pain feel better ***(check all that apply):***

☐ Rest ☐ Stop an activity ☐ Movement

☐ Ice ☐ Heat ☐ Pain medication

13. What makes the pain worse ***(check all that apply):***

☐ Bending ☐ Coughing ☐ Sneezing

☐ Lying down ☐ Sitting up ☐ Standing

☐ Staying in one position ☐ Movement

☐ Prolonged sitting

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QUESTIONNAIRE

13. How is this problem affecting your daily life? What are you having trouble with now:
(Check all that are significantly limited because of your problem and underline the most limited)

A. Self care: ☐ Showering ☐ Eating ☐ Dressing ☐ Bathing ☐ Toileting ☐ Putting on shoes/socks

B. Daily activities: ☐ Sitting ☐ Staying seated ☐ Standing ☐ Staying standing ☐ Driving a car
☐ Passenger in a car ☐ Getting in/out of car ☐ Changing position ☐ On/off chair ☐ In/out of bed

C. House hold tasks: ☐ Dusting/wiping ☐ Washing dishes ☐ Doing laundry ☐ Grocery shopping
☐ Preparing a meal ☐ Carrying items < 10 lbs. ☐ Carrying heavy items > 10 lbs. ☐ Pushing
☐ Pulling ☐ Reaching overhead ☐ Lifting overhead ☐ Lifting items floor to waist (counter height)
☐ Lifting items floor to chest height ☐ Sitting at computer ☐ Using a computer ☐ Desk/school work

14. ALLERGIES: ____

Do you smoke? ☐ Yes ☐ No

15. What medical conditions do you have: ☐ Cardiac ☐ Stroke ☐ High blood pressure ☐ Diabetes
☐ High cholesterol ☐ Neurological conditions ☐ Malignancies/cancer ☐ Seizures ☐ Infection
☐ Pregnancy: C-section (s) #____ vaginal birth(s) #____ ☐ Thyroid ☐ Cognitive deficits ☐ Dizziness
☐ Hard of hearing ☐ Long term use corticosteroids (circle one): Yes / No ☐ Other conditions:____________

16. What surgeries have you had? *(List all):*

Surgery	Date	Surgery	Date

17. What medications do you take and for what condition (you may provide a printed list we can copy):

Medication (indicate for what condition)	Dosage	Frequency	Administration: tablet/injection/patch

18. Anything you feel is important for us to know:

____

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