



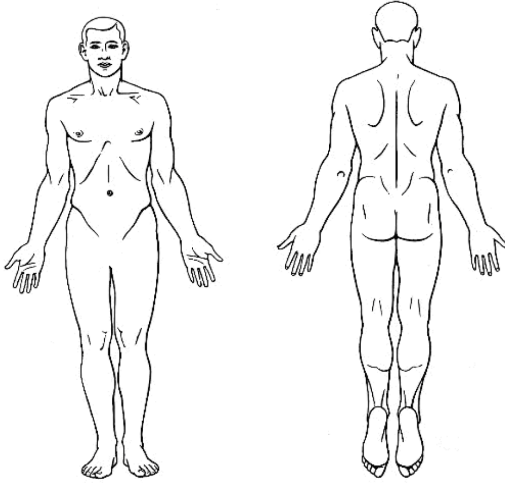
MOUNTAIN VALLEY PHYSICAL THERAPY

Patient Questionnaire

Name: _____ Age: _____ Date: _____

What is your chief complaint? _____

Indicate on the body chart where your problems are located:



Note:

Indicate pain with "XXX"

Indicate numbness with "000"

Indicate tingling with "ZZZ"

When and how did the problem begin? _____

What makes your symptoms/pain worse? _____

Rate your pain on a scale of 0-10 (with 0=no pain and 10=excruciating pain) _____

What is your occupation/job description? _____

Please list any recent diagnostic studies (CAT scan, MRI, X-ray, etc.) _____

Please list any surgeries _____

Do you have any limitations/restrictions from your physician? _____

What medications are you currently taking? _____

Is there a possibility that you are pregnant, and if so, how far along are you? _____

Please check any of the following you currently have or have had:

- | | | |
|--|---|--|
| <input type="checkbox"/> Bone or joint disease | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Breathing difficulty/Asthma |
| <input type="checkbox"/> Tendonitis/Bursitis | <input type="checkbox"/> Phlebitis/Varicose veins | <input type="checkbox"/> Emphysema/COPD |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Allergies, specify: _____ |
| <input type="checkbox"/> Jaw pain/TMJ | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Cancer/tumor |
| <input type="checkbox"/> Spinal problems | <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Bladder/kidney ailments |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Diabetes (Type I or II) | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Sleep disorders | <input type="checkbox"/> Migraines/Headaches |
| <input type="checkbox"/> Anxiety/stress syndrome | <input type="checkbox"/> Smoking (currently) | <input type="checkbox"/> Circulatory problems |
| <input type="checkbox"/> Seizures/fainting | <input type="checkbox"/> Autoimmune disease/HIV | |

How did you hear about MVPT (or who referred you?) _____