
PHYSICAL THERAPY PRE-EXAM QUESTIONNAIRE

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 Therapy before? Yes No
5. Where is your pain/ problem? _____
6. What caused your pain/ Problem? _____
7. Approximately what DATE did it start? ____/____/____
8. Is it getting worse, better or staying the same? _____
9. Have you had this pain problem before? Yes No
10. Is your pain constant? Yes No
11. On a scale of 1 to 10, what is your worst level of pain in the past couple of days?

1.....2.....3.....4.....5.....6.....7.....8.....9.....10
Mild Medium Severe

12. Are you taking any medication for this pain/ problem? Yes No
13. Are any of your USUAL activities affected? Yes No
-if yes, please describe _____
14. List any past surgery(s) with dates:

15. List all medical conditions you have (or have been told you have)

Patient Name _____ Date _____

Patient/ Guardian Signature _____