Patient's Name: _____

Today's Date: _____

Occupation: _____ Working? YES ☐ / No ☐

Physical Requirements of Job: _____

Hobbies: _____

Optimum Performance Physical Therapy PLLC
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Director OPPT

Subjective Questionnaire

What is your main reason for seeking treatment? _____

When did your problem begin? _____

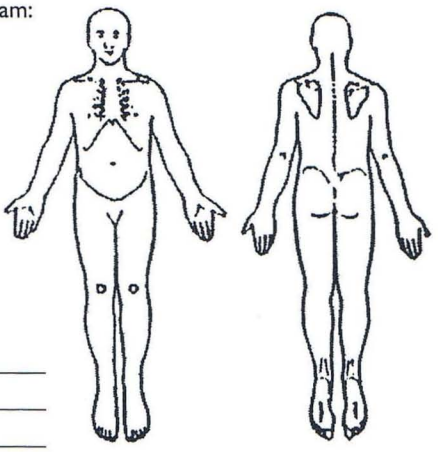
Is there any injury associated with your complaints? _____

If so, what was the date of your injury and how did it occur? _____

Did you have surgery: Yes ☐ No ☐ If yes, what kind? _____ Date of surgery: _____

Describe your pain / symptoms below by checking off boxes and shading appropriate areas on the body diagram:

Sharp ☐	Burning ☐	Constant ☐	Deep ☐	Hot ☐	Suffocating ☐
Dull ☐	Shooting ☐	Variable ☐	Heavy ☐	Cold ☐	Fearful ☐
Achy ☐	Throbbing ☐	Superficial ☐	Nauseating ☐	Tight ☐	Cruel ☐
	Radiating ☐ → If so, to where? _____				



Use scale below to identify the intensity of your pain on a daily basis.

Note specific number on 0 - 10 scale for most intense pain / symptom(s) and least level of symptom(s).

0 1 2 3 4 5 6 7 8 9 10

No Symptom(s) Severe Symptom(s)

How does your symptom(s) limit your work / daily activities? Minimally ☐ Moderately ☐ Severely ☐

Are you losing sleep due to the symptom(s)? Yes ☐ How much? _____ No ☐

What positions / activities INCREASE your symptoms? _____

How long does the more severe pain / symptom(s) last once aggravated? _____

What positions / activities DECREASE your symptoms? _____

How long can you sit _____ stand _____ walk _____ lift _____

Do you have any of the following? Please check all that apply.

Dizziness ☐	Double vision ☐	Chronic cough ☐	Confusion ☐
Ringing in the ears ☐	Speech problems ☐	Night pain ☐	Swelling ☐
Pain with coughing ☐	Hearing loss ☐	Passing out episodes ☐	Hypersensitivity ☐
Difficulty swallowing ☐	Face / jaw pain ☐	Headaches ☐	Pins / needles ☐
Loss of appetite ☐	Loss of vision ☐	Lack of coordination ☐	Numbness ☐
Sweating / nausea ☐	Fever / night sweats ☐	Changes in menstrual cycle ♀ ☐	Weight loss ☐
Diarrhea ☐	Pregnancy ♀ ☐	Prostate Problems ♂ ☐	Strength loss ☐
Change in symptoms with / after Eating ☐	Gynecological problems ♀ ☐	History of hernia ☐	Vertigo ☐
	Urinary or bowel leakage ☐	Pain with coughing / sneezing ☐	Instability ☐

What tests have been performed (i.e., X-Rays, MRI)? _____

Results of tests past and present? _____

What past surgeries have you had? _____

What medications are you taking for your current problem? _____

What medications are you taking for other medical problems? _____

What treatments have you had for this / these problem(s)? _____

Were they effective? _____

Check boxes below as appropriate, **Circle** boxes too if anyone in your family also suffers from any of the following:

Rheumatoid arthritis ☐	Smoker / Drinker ☐	Diabetes ☐
Osteoarthritis ☐	Past or present steroid use ☐ (i e prednisone)	Stroke ☐
Heart disease ☐	Emotional or stress disorders ☐	High Blood Pressure ☐
Lung disease ☐	Motor vehicle accident ☐	Cancer ☐
Other organ problems ☐	Head trauma ☐	Infectious Diseases ☐
Any autoimmune disease ☐	Balance disorders ☐	Inflammatory Diseases ☐
	Tendon / Muscle tears ☐	Clots/vascular problems ☐
		Fractures ☐

Other ☐ Explain: _____ Please initial _____

Thank you for taking the time to fill this subjective questionnaire out. It will help your therapist in treating you successfully.