Canyon Physical Therapy & Aquatic Rehabilitation
INITIAL PATIENT QUESTIONNAIRE

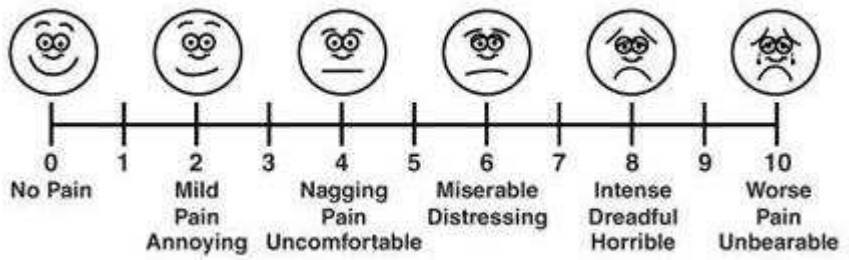
Name_____ Date_____ D.O.B._____
Height_____ Weight_____ Sex: ☐Male ☐Female ☐Right Handed ☐Left Handed

Chief Complaint (Injury/Condition/Surgery/Symptoms):_____
Type of Complaint: ☐Work Comp ☐Auto ☐Surgery ☐Gradual Onset ☐Sports ☐Other_____
Is your Complaint related to an accident? ☐YES ☐NO Type & Date of accident? _____
Description of Complaint:_____
_____
Date of Onset:_____ X-Ray Results:_____ MRI Results: _____
Surgery Date: _____ Type: _____
Have you had Physical Therapy for this or other conditions this year? ☐Yes ☐No Number of visits: _____

Treatments related to this injury (ie. Physical Therapy, Chiropractic, injections….)

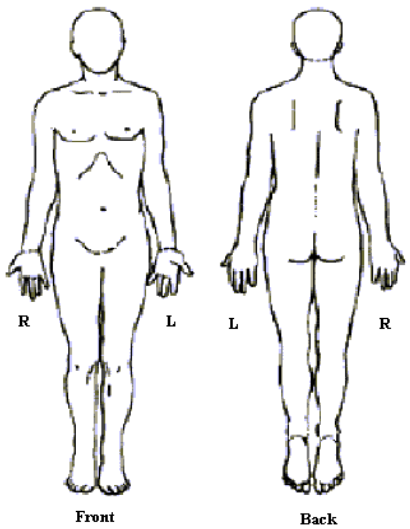
Treatment	Start Date	End Date	Outcome

Please rate your pain/symptoms on the line indicating your current (C), worst (W) and best (B) levels.



Easing Factors:_____
Aggravating Factors: _____
Is your condition getting….. ☐better ☐worse ☐about the same
Have you experienced similar problems in the past? ☐Yes ☐No
Functional Limitations (What are you unable to do, because of your current condition?): _____
_____
Goal(s) of Treament: _____
_____
Occupation (Describe duties/activities):_____
Sports, Hobbies, Recreational Activities: _____

Symptom Area & Description:



Please place symbols of your symptoms on the diagram to the left. Create your own symbols if necessary to describe your symptoms.

X = Sharp
S = Stiff
N = Numbness
A = Achy
D = Dull

Office Use
PT Initials:____