Canyon Physical Therapy and Aquatic Rehabilitation
INITIAL PATIENT QUESTIONNAIRE

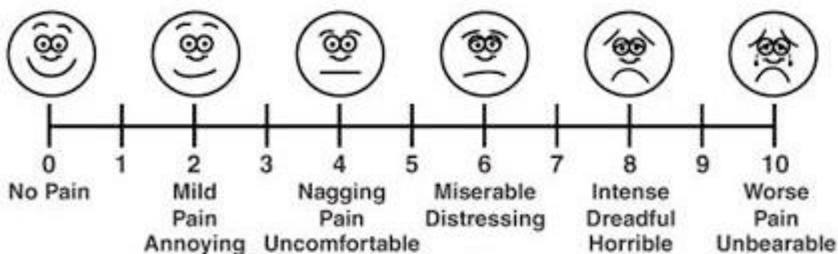
Name____ Date________________ D.O.B.________________
Height_______________ Weight_______________ Sex: ☐Male ☐Female ☐Right Handed ☐Left Handed

Chief Complaint (Injury/Condition/Surgery/Symptoms):____
Type of Complaint: ☐Work Comp ☐Auto ☐Surgery ☐Gradual Onset ☐Sports ☐Other_______________
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:

R L L R

Front Back

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 ☐