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# Initial Questionnaire



## HISTORY OF PRESENT CONDITION

1. What are your symptoms? \_\_\_\_\_

2. When did your symptoms begin (approximately)? \_\_\_\_\_

3. Which of the following **best describes** how your injury occurred? (check all that apply)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> lifting            | <input type="checkbox"/> trauma                   | <input type="checkbox"/> hit by a ball      |
| <input type="checkbox"/> MVA (car accident) | <input type="checkbox"/> degenerative process     | <input type="checkbox"/> dental appointment |
| <input type="checkbox"/> a fall             | <input type="checkbox"/> during recreation/sports | <input type="checkbox"/> throwing           |
| <input type="checkbox"/> cumulative trauma  | <input type="checkbox"/> running                  | <input type="checkbox"/> unknown            |
| <input type="checkbox"/> overuse            | <input type="checkbox"/> blow to the face         | <input type="checkbox"/> List other below   |
- 
- 

4. Nature of pain/symptoms (check all that apply)

- |                                 |                                     |                                       |                                   |                               |
|---------------------------------|-------------------------------------|---------------------------------------|-----------------------------------|-------------------------------|
| <input type="checkbox"/> Sharp  | <input type="checkbox"/> Throbbing  | <input type="checkbox"/> Periodic     | <input type="checkbox"/> Constant | <input type="checkbox"/> Dull |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Occasional | <input type="checkbox"/> Other: _____ |                                   |                               |

5. Other Medical Symptoms? (check all that apply)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Bowel / Bladder difficulty | <input type="checkbox"/> Dizziness / Fainting attacks | <input type="checkbox"/> Malaise                   |
| <input type="checkbox"/> Fever / Chills             | <input type="checkbox"/> Weakness                     | <input type="checkbox"/> Vision / Hearing problems |
| <input type="checkbox"/> Genital / Anal numbness    | <input type="checkbox"/> Weight gain / loss           | <input type="checkbox"/> None noted                |
| <input type="checkbox"/> Numbness                   | <input type="checkbox"/> Night pain / sweats          | <input type="checkbox"/> List other below          |
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6. Have you had any previous treatment for this condition? (check all that apply)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> None                     | <input type="checkbox"/> Bracing / taping                 | <input type="checkbox"/> TENS unit                 |
| <input type="checkbox"/> Medication (oral)        | <input type="checkbox"/> Injection into the spine         | <input type="checkbox"/> Acupuncture               |
| <input type="checkbox"/> Joint manipulation DC/DO | <input type="checkbox"/> Injection into the skin / muscle | <input type="checkbox"/> Bed Rest                  |
| <input type="checkbox"/> Exercise                 | <input type="checkbox"/> Physical Therapy                 | <input type="checkbox"/> Overnight hospitalization |
| <input type="checkbox"/> Massage therapy          | <input type="checkbox"/> Hypnosis                         | <input type="checkbox"/> Casting                   |
| <input type="checkbox"/> Traction                 | <input type="checkbox"/> Biofeedback                      | <input type="checkbox"/> List other below          |
- 
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7. Have you had any of the following tests? (check all that apply)

- |                                  |  |                                       |                                      |
|----------------------------------|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> None    | <input type="checkbox"/> MRI               | <input type="checkbox"/> Bone Scan    | <input type="checkbox"/> Vestibular  |
| <input type="checkbox"/> X-rays  | <input type="checkbox"/> Arthrogram        | <input type="checkbox"/> NCS          | <input type="checkbox"/> Fluoroscope |
| <input type="checkbox"/> CT scan | <input type="checkbox"/> Stress X-ray test | <input type="checkbox"/> Other: _____ |                                      |
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8. Other Medical Condition (check all that apply)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Cancer                                  | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Psychological Issues            |
| <input type="checkbox"/> Heart Problems                          | <input type="checkbox"/> Hypertension       | <input type="checkbox"/> Thyroid Problems                |
| <input type="checkbox"/> Kidney Problems                         | <input type="checkbox"/> Stomach Problems   | <input type="checkbox"/> Lung Problems                   |
| <input type="checkbox"/> Neurological Disorders                  | <input type="checkbox"/> Cognitive Problems | <input type="checkbox"/> Epilepsy / Seizures             |
| <input type="checkbox"/> Fracture                                | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Arthritis                       |
| <input type="checkbox"/> Rheumatoid Arthritis                    | <input type="checkbox"/> Blood Disorders    | <input type="checkbox"/> Circulation / Vascular Problems |
| <input type="checkbox"/> Stroke                                  | <input type="checkbox"/> Allergies          | <input type="checkbox"/> Obesity                         |
| <input type="checkbox"/> Infectious Disease (Hepatitis, TB, HIV) | <input type="checkbox"/> Other: _____       |  |

**MEDICATION**

Are you currently taking any medication for the **specific condition** (ailment or injury) for which you are seeking rehabilitative care?

- Prescription (please specify): \_\_\_\_\_
- Non-prescription (please specify): \_\_\_\_\_
- Other (please specify): \_\_\_\_\_
- None

**PRIMARY REASON FOR CHOOSING WESTARM THERAPY SERVICES (Please circle only one):**

- |                               |                   |                              |                    |
|-------------------------------|-------------------|------------------------------|--------------------|
| Appointment availability      | Billboard         | Community event              | Doctor recommended |
| Employer directed             | Friend            | Insurance                    | Location           |
| Newspaper                     | Previous patient  | Referred by WESTARM employee | Relative           |
| Service / program             | TV and / or radio | Website                      | WESTARM Homecare   |
| Yellow pages / telephone book | Other: _____      |                              |                    |

**EMERGENCY INFORMATION**

Emergency Contact Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_