Tranquillity Physical Therapy, Inc.

Making a Difference in Patient's Rehabilitation Care.

Patient Questionnaire

Welcome to Tranquillity! To provide you with the best, most comprehensive care possible, we request that you provide the following information. All information is held strictly confidential and is released only with your written permission.

Name_______________________________________

Referring Physician____________________________

Date___________________________ **Onset Date:** _______________________

Pain Rating

0	1	2	3	4	5	6	7	8	9	10
No Pain		Moderate			Strong		Very Strong		Emergency	

Chose the number from the above pain rating chart that best describes the severity of your pain

On the average__________ At its best___________ At its worst___________

What percentage of the day you have pain or discomfort?

0% 20% 40% 60% 80% 100%

Is your pain worse in the ________Morning________ Evening________ Both________ Other?

Explain____
____

Describe or illustrate your symptoms on the diagram using these symbols

//// Stabbing XXX Burning 000 Pins and Needles = = = Numbness >>>>> Shooting

Other description of your symptoms ____
____

Work History

Do you work or did you work at the time of illness? ______Yes ______ No.

If yes answer the following. What is/was you job title? ______________________

Which work task affects your pain? _____________________________________

Are you currently on disability? _____Yes ______ No.

	Doctor Notes *Please do not write in this **area***
Presenting Problem or Proposed Surgery:______________________________ ____ ____	

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Have you had any of the following:

	Yes	No		Yes	No
Allergies, asthma, hay fever			Migraine Headaches		
Anemia			Rheumatic Fever		
Alcoholism			Stroke		
Arthritis			Suicide Attempts		
Bleeding problems			Thyroid Disease/Goiter		
Birth defects			Tuberculosis		
Cancer			Ulcers		
Emphysema			Venereal Disease		
Epilepsy or seizures			Osteoporosis		
Heart Trouble			Glaucoma		
Mental illness			Gall Stones		

Names of Other Present Physicians	Last Visit	

ALLERGIES: Please list type and reaction NONE

Name of Drug/Item	Reaction	Name of Drug/Item	Reaction

What current medications are you currently taking?

Please List Name of Medication, Dosage, and Frequency:

Blood pressure pills________________

Cortisone/steroids_________________

Diabetes pills ____________________

Thyroid pills _____________________

Tranquilizers _____________________

Water pills _______________________

Aspirin ___________________________

Antibiotics _________________________

Blood Thinners ____________________

Laxatives __________________________

Pain Medications ___________________

Sleeping pill _______________________

Vitamins ___________________________

Other Please List: ___________________

Past Medical History:

Surgeries	Date	Major Illnesses or Injury	Date

______________________ Patient Signature

______________________ Date

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