inmotion
PHYSICAL THERAPY

Patient Questionnaire Sheet

Patient Name: _____ Date of Birth: _____ Referral Source: _____

PERSONAL INFORMATION

Height:_____ Weight:_____

I am currently: (check one) ☐ Employed, ☐ Employed with restrictions, ☐ On medical leave, ☐ Not Employed

Employer: _____ Occupation: _____

Interests/hobbies/exercise: _____

Smoking Status: ☐ YES or ☐ NO

Will you have any problems attending therapy sessions? ☐ YES or ☐ NO If yes, please describe:

Next scheduled Dr appointment(s) Date _____ Physician _____

Date _____ Physician _____

What medications are you currently taking:

Any known Allergies:_____

Please give a brief description of your past medical history including any surgeries, allergies, and diagnosed diseases:

Please give a brief description of your family history:

KEY QUESTIONS ABOUT YOUR CONDITION

What is your MAIN complaint?