Patient Name: ________________________________________ Date: ________

Please describe the problem/condition that brought you to therapy:

_________________________________________________________________________________
_________________________________________________________________________________

How did your problem/condition begin? ________________________________________________

What are you hoping to get out of your therapy – what are your goals? ____________________

Approximately how long can you perform the following activities comfortably?

☐ Sitting __________ minutes
☐ Standing __________ minutes
☐ Walking __________ minutes

Which of the activities listed below are you having difficulty or discomfort with because of your injury?

☐ Sitting ☐ Combing hair ☐ Cleaning tub
☐ Standing ☐ Brushing teeth ☐ Making bed
☐ Walking ☐ Dressing self ☐ Dusting
☐ Going up stairs ☐ Putting on shoes/socks ☐ Doing dishes
☐ Going down stairs ☐ Sleeping ☐ Cooking
☐ Reaching ☐ Shaving ☐ Planting and gardening
☐ Reaching overhead ☐ Bathing ☐ Mowing
☐ Lifting ☐ Driving ☐ Snow shoveling
☐ Carrying ☐ Vacuuming
☐ Sex ☐ Laundry

Recreational Activities: ________________________________________________________________

Are there any recreational activities you are not doing now because of your injury? _______________
VERTICAL MOTION PHYSICAL THERAPY – PAIN QUESTIONNAIRE

Circle two numbers below to indicate your pain at best and worst over the past week:
(No pain) 0___ 1___ 2___ 3___ 4___ 5___ 6___ 7___ 8___ 9___ 10___ (Severe pain)

Mark the areas where you feel the described sensations on your body. Use the appropriate symbol. Mark areas of radiation. Include all affected areas related to your current problem.

Pain XXXX  Numbness ====  Tingling ####