For Office Use Only
Chart Number:_____
Reviewed by:_____

SPECTRUM MEDICAL PHYSICAL THERAPY
PAIN & SYMPTOMS QUESTIONNAIRE

Name: _____ Age:___ Date:_____ Email:_____

What is your present condition and/or mechanism of injury? _____
_____

What is your primary concern or chief complaint? _____
_____

How would you describe your pain? _____

What makes the pain worse? _____
_____

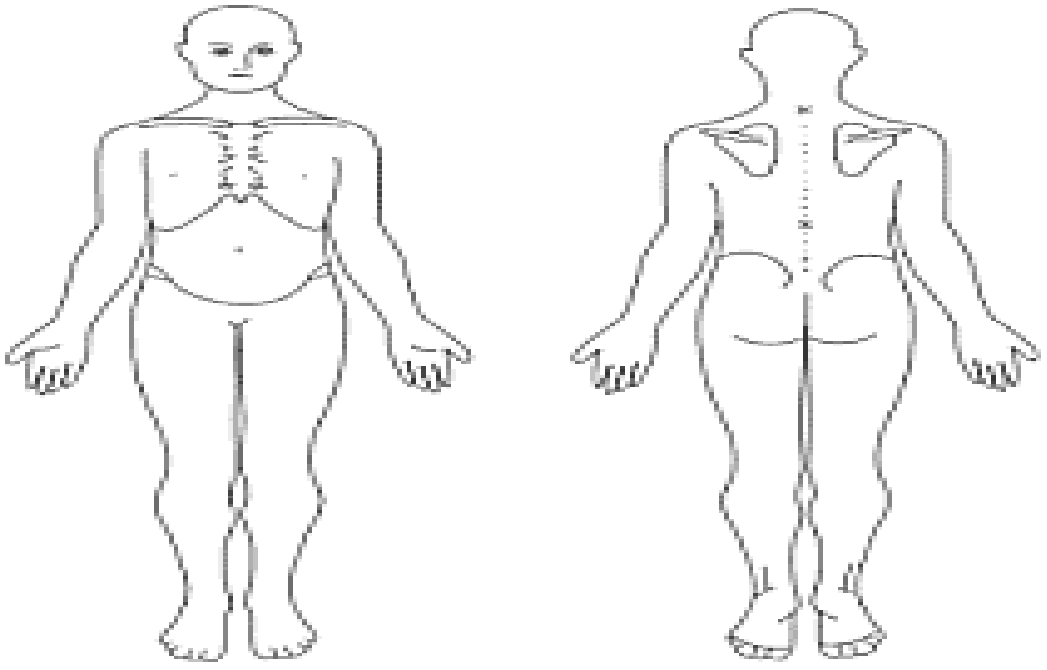
What eases your pain? _____
_____

Rate the pain of your primary concern on the following scale by circling the number that best corresponds.

0 = None 5 = Moderate 10 = Extreme

Current Pain:	0	1	2	3	4	5	6	7	8	9	10
Best:	0	1	2	3	4	5	6	7	8	9	10
Worst:	0	1	2	3	4	5	6	7	8	9	10

Indicate where your pain is located and what type of pain you feel at the present time.



Please check **all** that apply to your medical history:

- ❑ Osteoarthritis
- ❑ Cardiovascular Disease
- ❑ Diabetes Mellitus Type 1
- ❑ Diabetes Mellitus Type 2
- ❑ Allergies
- ❑ Complication Factors
- ❑ Surgical History
- ❑ Previous Physical Therapy for this concern
- ❑ Psycho-Social
- ❑ History of Cancer
- ❑ Current Infection
- ❑ Immunosuppression
- ❑ Fracture or Suspected Fracture
- ❑ Cauda Equina Syndrome
- ❑ Diagnostic Testing (MRI, X-Ray, etc)
- ❑

If you checked any of the above boxes, please explain. _____
_____
_____
_____

How would you rate your overall general health? (Circle the **one** that applies best.)

Good Fair Poor

Please state your goal of physical therapy: _____
_____

By signing below, I consent to a physical therapy evaluation and treatment.

Patient Signature: _____ Date: _____

Joe Nicholson, PT – Director
Mary Ellen Woods, MS, PT, COMT
Cortney Herndon, DPT, COMT
Leslie Lovelace, MS, PT
Patti Snead, DPT
John Wilkinson, DPT
Heath Hylton, PTA, CMT
Shelly Lewis, PTA
Alexis Farmer, PTA
Aaron Taylor, MS, ATC
Tim Torborg, ATC

FUNCTIONAL CAPACITY EVALUATION (FCE) - IMPAIRMENT RATING INFORMATION

NAME: _____ **DATE:** _____ **DOB:** _____

ADDRESS: _____ **PHONE:** _____

DIAGNOSIS: _____ **PHYSICIAN:**_____

DATE of INJURY: _____ **DATE(S) of SURGERY:** _____

HOW DID YOU GET INJURED: _____

_____

EMPLOYER: _____ **OCCUPATION:**_____

EMPLOYER ADDRESS: _____

EMPLOYER'S PHONE NUMBER: _____ **ARE YOU WORKING? YES or NO**

IF YES, HOW MUCH ARE YOU WORKING? _____

_____

Information about your Functional Capacity Evaluation (FCE) or Impairment Rating

- **DURATION:** Please be at the DOC Rehab at least 15 minutes before your appointment time to complete any paperwork necessary for your visit.
    - ✓ Functional Capacity Evaluations (FCE) may take as long as long as 4 - 5 hours to complete.
    - ✓ Impairment Ratings may take as long as 1 hour to complete.
- **DRESS:** Please dress as you would for a regular work day. Do not wear tight fitting clothes as these may affect your ability to complete some of the tasks you need to perform in the evaluation, such as lifting.
- **FAMILY or FRIENDS:** They will be unable to accompany you in the evaluation as they may distract or hinder your performance in the evaluation.
- **MEDICATIONS:** We request that you take only essential medications (heart, diabetic, blood pressure) on the day of your evaluation and avoid taking anything for pain unless absolutely necessary. Please bring any medications with you in case you need them during or after the evaluation.
- **TOOLS & EQUIPMENT:** Please bring any tools or work equipment that you think may be useful to simulate your work during the evaluation. These may include a tool belt, tool box, work boots, etc.

We look forward to being able to assist you with this evaluation. If you have any questions, please do not hesitate to call.

Sincerely and Thank you,
Aaron Taylor, MS, ATC